Exhibit 3(i): Gensia

- J0640

EMPLOYEE	DEPENDENT (IF APPLICABLE)	RELATIONSHIP
		S

PROVIDER TAX I.D. #:	PATIENT ACCOUNT #
042767880	10

NO 0588583

12/20/2002
DATE ISSUED

SHEET METAL WORKERS' NATIONAL HEALTH FUND
P.O. BOX 1449 • GOODLETTSVILLE, TN 37070-1449

PAY ********95DOLLARS AND 20CENTS** DOLLARS $ *****95.20**

TO THE ORDER OF

HALLMARK HEALTH SYSTEM, INC.
100 HOSPITAL RD
MALDEN , MA 02148

0588583

AUTHORIZED SIGNATURE

NON NEGOTIABLE

AUTHORIZED SIGNATURE

BankTrust Bank, Nashville
Nashville, Tennessee 37220

⑈0058858 3⑈ ⑆064000046⑆ 702139030 2⑈

SHEET METAL WORKERS' NATIONAL HEALTH FUND

P.O. Box 1449
Goodlettsville, Tennessee 37070-1449
Toll-Free 800-831-4914 | Phone (615) 859-0131

SMW+ PROGRAM

EXPLANATION OF BENEFITS

FROM DATE	TO DATE	CHARGES SUBMITTED	NON COVERED	CHARGES ALLOWED	COVERED CHARGES	AMOUNT PAID
10/01/2002	10/31/2002	2720.00	.00	95.20	95.20	95.20
		2720.00	.00	95.20	95.20	95.20

NON-COVERED CODES:

REDACTED

COMMENTS:

PROVIDER: HALLMARK HEALTH SYSTEM, INC.
PARTICIPANT
CDP CLAIM NUMBER: 2005050

BRADFORD MA 01835

Processed by SOUTHERN BENEFIT ADMINISTRATORS, INC.

APPROVED OMB NO. 0938-279

HALLMARK HEALTH 100 HOSPITAL RD MALDEN 1 MA02148 0000000000	2				3 PATIENT CONTROL NUMBER					4 TYPE OF BILL 131
5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11			
0042767880	100102	103102	30	0	0	0				

12 PATIENT'S NAME — 13 PATIENT'S ADDRESS: BRADFORD, MA 01835-

14 BIRTHDATE	15 SEX	16 MS	17 DATE ADMISSION	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	24	25	26	27	28	29	30	31
										CONDITION CODES							
02251947	F	M	10012002	07	3	2	99	01	H0081528								

32 CODE	32 OCCURRENCE DATE	33 CODE	33 OCCURRENCE DATE	34 CODE	34 OCCURRENCE DATE	35 CODE	35 OCCURRENCE DATE	36 CODE	36 OCCURRENCE SPAN FROM	THROUGH	37
											A B C

38 SHEET METAL WORKERS

REDACTED 12/14/07

	39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT
a	88	2405.80			A2	95.20
b						
c						
d						

42 REV.CD	43 DESCRIPTION	44 HCPCS/RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0250	PHARMACY		102902	1	400	000	
0280	ONCOLOGY	99212	100102	1	7300	7300	
0280	ONCOLOGY	99214	100802	1	10600	000	
0280	ONCOLOGY	99212	101502	1	7300	7300	
0280	ONCOLOGY	99213	102202	1	9100	000	
0280	ONCOLOGY	99212	102902	1	7300	7300	
0300	LABORATORY	G0001	100102	1	1400	000	
0300	LABORATORY	G0001	101502	1	1400	000	
0300	LABORATORY	G0001	102902	1	1400	000	
0305	LAB/HEMATOLOGY	85025	100102	1	3000	000	
0305	LAB/HEMATOLOGY	85025	101502	1	3000	000	
0305	LAB/HEMATOLOGY	85025	102902	1	3000	000	
0331	CHEMOTHER/INJ	Q0083	100102	1	27800	000	
0331	CHEMOTHER/INJ	Q0083	100802	1	27800	000	
0331	CHEMOTHER/INJ	Q0083	101502	1	27800	000	
0331	CHEMOTHER/INJ	Q0083	102902	1	27800	000	
0636	DRUGS/DETAIL CODE	J0640	100102	1	6000	000	
0636	DRUGS/DETAIL CODE	J9190	100102	2	2600	000	
0636	DRUGS/DETAIL CODE	Q0166	100102	1	17800	000	
0636	DRUGS/DETAIL CODE	J0640	100802	1	6000	000	
0636	DRUGS/DETAIL CODE	J9190	100802	2	2600	000	
0636	DRUGS/DETAIL CODE	Q0166	100802	1	17800	000	

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
PAGE: 01 OF 02						
MEDICARE PART A	220070	Y	Y	240580		
SHEET METAL WORKERS		N	Y		9520	
DUE FROM PATIENT			H			

57 INSURED'S NAME	59 P REL	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
	01		DISABLED	UNKNOWN
	02		DISABLED	UNKNOWN

63 TREATMENT AUTHORIZATION CODES	64 ES	65 EMPLOYER NAME	66 EMPLOYER LOCATION
			EOB ATTACHED

67 PRIN.DIAG CD.	68 CODE	69 CODE	OTHER DIAG CODES 70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM DIAG CD.	77 E-CODE	78
1539											

79 PC	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
9						
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE

82 ATTENDING PHYS ID B72551
PENNACCHIO JOSEPH
83 OTHER PHYS ID A
OTHER PHYS ID B72551 B
PENNACCHIO JOSEPH

84 REMARKS SHEET METAL WORKERS
PO BOX 1449
GOODLETTSVILLE, TN 37070-1449

85 PROVIDER REPRESENTATIVE KATHY MARINELLI — 86 DATE 110702002

APPROVED OMB NO. 0938-279

HALLMARK HEALTH 100 HOSPITAL RD MALDEN 1 MA02148 0000000000	2				3 PATIENT CONTROL NUMBER					4 TYPE OF BILL 131
5 FED. TAX NO. 0042767880	6 STATEMENT COVERS PERIOD FROM 100102	THROUGH 103102	7 COV'D. 30	8 N-C'D. 0	9 C-I'D. 0	10 L-R'D. 0	11			
12 PATIENT'S NAME	13 PATIENT'S ADDRESS BRADFORD, MA 01835-									
14 BIRTHDATE 02251947	15 SEX F	16 MS M	17 ADMISSION DATE 10012002	18 HR 07	19 TYPE 3	20 SRC 2	21 D HR 99	22 STAT 01	23 MEDICAL RECORD NO. H0081528	24 25 26 27 28 29 30 31 CONDITION CODES
32 OCCURRENCE CODE DATE	33 OCCURRENCE CODE DATE	34 OCCURRENCE CODE DATE	35 OCCURRENCE CODE DATE	36 OCCURRENCE CODE DATE	37 OCCURRENCE SPAN CODE FROM THROUGH					
38 SHEET METAL WORKERS	REDACTED									

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	88	2405.80			A2	95.20
b						
c						
d						

42 REV. CD	43 DESCRIPTION	44 HCPCS/RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0636	DRUGS/DETAIL CODE	J0640	101502	1	6000	000	
0636	DRUGS/DETAIL CODE	J9190	101502	2	2600	000	
0636	DRUGS/DETAIL CODE	Q0166	101502	1	17800	000	
0636	DRUGS/DETAIL CODE	J0640	102902	1	6000	000	
0636	DRUGS/DETAIL CODE	J9190	102902	2	2600	000	
0636	DRUGS/DETAIL CODE	Q0166	102902	1	17800	000	
0001	TOTAL CHARGES			32	272000	21900	

50 PAYER	51 PROVIDER NO.	52 REL ASSG. YES	52 REL ASSG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
PAGE: 02 OF 02						
MEDICARE PART A	220070	Y	Y	240580		
SHEET METAL WORKERS		Y	Y		9520	
	DUE FROM PATIENT					

58 INSURED'S NAME	59 P REL	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
	01		DISABLED	UNKNOWN
	02		DISABLED	UNKNOWN

63 TREATMENT AUTHORIZATION CODES	64 ES	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN. DIAG CD.	68 CODE	69 CODE	70 CODE	OTHER DIAG CODES 71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM DIAG CD.	77 E-CODE	78
1539											

79 PC	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
9						
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE

82 ATTENDING PHYS. ID	B72551
	PENNACCHIO JOSEPH
83 OTHER PHYS. ID	A
OTHER PHYS. ID	B72551 B
	PENNACCHIO JOSEPH
85 PROVIDER REPRESENTATIVE	86 DATE
KATHY MARINELLI	110702002

84 REMARKS
SHEET METAL WORKERS
PO BOX 1449
GOODLETTSVILLE, TN 37070-1449

MEDICARE NATIONAL STANDARD INTERMEDIARY REMITTANCE ADVICE

HALLMARK HEALTH SYSTEMS
100 HOSPITAL ROAD
MALDEN MA 02148

PROVIDER: 220070 MEDICARE
ENDING: 10/31/2002
BILL TYPE: 131

NAME:
HIC:
MRN: H0081528

PCN: V19070457 1
ICN: 1231539763

SERVICE: 10/01/2002 THRU 10/31/2002
MEDICARE PAYMENT DATE: 12/03/2002
PAT STAT: 01 CLAIM STAT: 1

CHARGES		PPS DATA		PAYMENT DATA	
REPORTED	2720.00	DRG	000	REIMB RATE	0.00
NON-COVERED	219.00	DRG AMOUNT	0.00	PROF COMP	0.00
DENIED	0.00	DRG/OPERATION	0.00	PERDIEM	0
		DRG/CAPITAL	0.00	INTEREST	0.00
		OUTLIER( )	0.00		
DAYS					
		BLOOD DEDUCT	0.00		
COVERED DAYS	0000	TOTAL DEDUCT	0.00	CONT ADJ AMT	1957.70
NON-COVERED DAYS	0000	CO-INSURANCE	95.20	NET REIMB AMT	448.10

REDACTED

Exhibit 3(j): Immunex

- J0640
- J9260
- J9293

EMPLOYEE	DEPENDENT (IF APPLICABLE)	RELATIONSHIP
		S

PROVIDER TAX I.D. #:	PATIENT ACCOUNT #
042767880	10

NO 0588583

12/20/2002
DATE ISSUED

SHEET METAL WORKERS' NATIONAL HEALTH FUND
P.O. BOX 1449 • GOODLETTSVILLE, TN 37070-1449

PAY **********95DOLLARS AND 20CENTS** DOLLARS $ *****95.20**

TO THE ORDER OF

0588583

HALLMARK HEALTH SYSTEM, INC.
100 HOSPITAL RD

MALDEN , MA 02148

AUTHORIZED SIGNATURE

NON NEGOTIABLE

AUTHORIZED SIGNATURE

SunTrust Bank, Nashville
Nashville, Tennessee 37230

⑈0058858 3⑈ ⑆064000046⑆ 702139030 2⑈

SHEET METAL WORKERS' NATIONAL HEALTH FUND

P.O. Box 1449
Goodlettsville, Tennessee 37070-1449
Toll-Free 800-831-4914 | Phone (615) 859-0131

SMW+ PROGRAM

EXPLANATION OF BENEFITS

FROM DATE	TO DATE	CHARGES SUBMITTED	NON COVERED	CHARGES ALLOWED	COVERED CHARGES	AMOUNT PAID
10/01/2002	10/31/2002	2720.00	.00	95.20	95.20	95.20
		2720.00	.00	95.20	95.20	95.20

NON-COVERED CODES:

REDACTED

COMMENTS:

PROVIDER: HALLMARK HEALTH SYSTEM, INC.
PARTICIPANT
CDF CLAIM NUMBER: 2005050

BRADFORD MA 01835

Processed by SOUTHERN BENEFIT ADMINISTRATORS, INC.

APPROVED OMB NO. 0938-279

HALLMARK HEALTH 100 HOSPITAL RD MALDEN 1 MA02148 0000000000	2					3 PATIENT CONTROL NUMBER				4 TYPE OF BILL 131
	5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV'D.	8 N-C'D.	9 C-I'D.	10 L-R'D.	11		
	0042767880	100102	103102	30	0	0	0			

12 PATIENT'S NAME: REDACTED 12/14/06

13 PATIENT'S ADDRESS: BRADFORD, MA 01835-

14 BIRTHDATE	15 SEX	16 MS	17 ADMISSION DATE	18 HR	19 TYP	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	24-30 CONDITION CODES	31
02251947	F	M	10012002	07	3	2	99	01	H0081528		

32 CODE	33 OCCURRENCE DATE	34 CODE	35 OCCURRENCE DATE	36 CODE	37 OCCURRENCE DATE	38 CODE	39 OCCURRENCE SPAN FROM	THROUGH	37
									A B C

38 SHEET METAL WORKERS

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	88	2405.80			A2	95.20
b						
c						
d						

42 REV.CD	43 DESCRIPTION	44 HCPCS/RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0250	PHARMACY		102902	1	400	000	
0280	ONCOLOGY	99212	100102	1	7300	7300	
0280	ONCOLOGY	99214	100802	1	10600	000	
0280	ONCOLOGY	99212	101502	1	7300	7300	
0280	ONCOLOGY	99213	102202	1	9100	000	
0280	ONCOLOGY	99212	102902	1	7300	7300	
0300	LABORATORY	G0001	100102	1	1400	000	
0300	LABORATORY	G0001	101502	1	1400	000	
0300	LABORATORY	G0001	102902	1	1400	000	
0305	LAB/HEMATOLOGY	85025	100102	1	3000	000	
0305	LAB/HEMATOLOGY	85025	101502	1	3000	000	
0305	LAB/HEMATOLOGY	85025	102902	1	3000	000	
0331	CHEMOTHER/INJ	Q0083	100102	1	27800	000	
0331	CHEMOTHER/INJ	Q0083	100802	1	27800	000	
0331	CHEMOTHER/INJ	Q0083	101502	1	27800	000	
0331	CHEMOTHER/INJ	Q0083	102902	1	27800	000	
0636	DRUGS/DETAIL CODE	J0640	100102	1	6000	000	
0636	DRUGS/DETAIL CODE	J9190	100102	2	2600	000	
0636	DRUGS/DETAIL CODE	Q0166	100102	1	17800	000	
0636	DRUGS/DETAIL CODE	J0640	100802	1	6000	000	
0636	DRUGS/DETAIL CODE	J9190	100802	2	2600	000	
0636	DRUGS/DETAIL CODE	Q0166	100802	1	17800	000	

50 PAYER	51 PROVIDER NO.	52 REL CD	52 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
PAGE: 01 OF 02						
MEDICARE PART A	220070	Y	Y	240580		
SHEET METAL WORKERS		Y	Y		9520	
	DUE FROM PATIENT					

58 INSURED'S NAME	59 P.REL	60 CERT.-SSN-HIC,-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
	01		DISABLED	UNKNOWN
	02		DISABLED	UNKNOWN

63 TREATMENT AUTHORIZATION CODES	64 ES	65 EMPLOYER NAME	66 EMPLOYER LOCATION
			EOB ATTACHED

67 PRIN.DIAG CD.	68 CODE	69 CODE	70 CODE	OTHER DIAG CODES 71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM.DIAG.CD.	77 E-CODE	78
1539											

79 PC	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
9						
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE

82 ATTENDING PHYS. ID: B72551
PENNACCHIO JOSEPH

83 OTHER PHYS. ID: A

OTHER PHYS. ID: B72551
PENNACCHIO B JOSEPH

84 REMARKS: SHEET METAL WORKERS
PO BOX 1449
GOODLETTSVILLE, TN 37070-1449

85 PROVIDER REPRESENTATIVE: KATHY MARINELLI 88 DATE: 11072002

APPROVED OMB NO. 0938-0279

HALLMARK HEALTH 100 HOSPITAL RD MALDEN 1 MA02148 0000000000	2	3 PATIENT CONTROL NUMBER							4 TYPE OF BILL 131
	5 FED. TAX NO. 0042767880	6 STATEMENT COVERS PERIOD FROM 100102	THROUGH 103102	7 COV D. 30	8 N-CD. 0	9 C-I D. 0	10 L-R D. 0	11	
12 PATIENT'S NAME	13 PATIENT'S ADDRESS BRADFORD, MA 01835-								

14 BIRTHDATE	15 SEX	16 MS	17 ADMISSION DATE	18 HR	19 TYP	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	24-30 CONDITION CODES	31
02251947	F	M	10012002	07	3	2	99	01	H0081528		

32 CODE	32 OCCURRENCE DATE	33 CODE	33 OCCURRENCE DATE	34 CODE	34 OCCURRENCE DATE	35 CODE	35 OCCURRENCE DATE	36 CODE	36 OCCURRENCE SPAN FROM	THROUGH	37
											A B C

38 SHEET METAL WORKERS

REDACTED

39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a 88	2405.80			A2	95.20
b					
c					
d					

42 REV.CD	43 DESCRIPTION	44 HCPCS/RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0636	DRUGS/DETAIL CODE	J0640	101502	1	6000	000	
0636	DRUGS/DETAIL CODE	J9190	101502	2	2600	000	
0636	DRUGS/DETAIL CODE	Q0166	101502	1	17800	000	
0636	DRUGS/DETAIL CODE	J0640	102902	1	6000	000	
0636	DRUGS/DETAIL CODE	J9190	102902	2	2600	000	
0636	DRUGS/DETAIL CODE	Q0166	102902	1	17800	000	
0001	TOTAL CHARGES			32	272000	21900	

50 PAYER	51 PROVIDER NO.	52 REL. INFO	53 ASSIGN BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
PAGE: 02 OF 02 MEDICARE PART A	220070	Y	Y	240580	9520	
SHEET METAL WORKERS		Y	Y			
				DUE FROM PATIENT		

57 INSURED'S NAME	58 P.REL	59 CERT.-SSN-HIC.-ID NO.	60 GROUP NAME	61 INSURANCE GROUP NO.
	01		DISABLED	UNKNOWN
	02		DISABLED	UNKNOWN

62 TREATMENT AUTHORIZATION CODES	64 ES	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN.DIAG CD.	68 CODE	69 CODE	70 CODE	OTHER DIAG CODES 71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM DIAG CD.	77 E-CODE	78
1539											

79 PC	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
9						
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE

82 ATTENDING PHYS. ID	
B72551	
PENNACCHIO	JOSEPH
83 OTHER PHYS. ID	
A	
OTHER PHYS. ID B72551	B
PENNACCHIO	JOSEPH

84 REMARKS SHEET METAL WORKERS
PO BOX 1449
GOODLETTSVILLE, TN 37070-1449

85 PROVIDER REPRESENTATIVE	86 DATE
KATHY MARINELLI	110702002

MEDICARE NATIONAL STANDARD INTERMEDIARY REMITTANCE ADVICE

HALLMARK HEALTH SYSTEMS
100 HOSPITAL ROAD
MALDEN MA 02148

PROVIDER: 220070 MEDICARE
ENDING: 10/31/2002
BILL TYPE: 131

NAME:
HIC:
MRN: H0081528

PCN: V19070457 1
ICN: 1231539763

SERVICE: 10/01/2002 THRU 10/31/2002
MEDICARE PAYMENT DATE: 12/03/2002
PAT STAT: 01 CLAIM STAT: 1

CHARGES		PPS DATA		PAYMENT DATA	
REPORTED	2720.00	DRG	000	REIMB RATE	0.00
NON-COVERED	219.00	DRG AMOUNT	0.00	PROF COMP	0.00
DENIED	0.00	DRG/OPERATION	0.00	PERDIEM	0
		DRG/CAPITAL	0.00	INTEREST	0.00
		OUTLIER( )	0.00		
DAYS					
		BLOOD DEDUCT	0.00		
COVERED DAYS	0000	TOTAL DEDUCT	0.00	CONT ADJ AMT	1957.70
NON-COVERED DAYS	0000	CO-INSURANCE	95.20	NET REIMB AMT	448.10

REDACTED

13

REDACTED

09/13/2001
Date Issued

Amount Paid: $4.54

NEW BEDFORD, MA 02740

File Copy This is not a Check

SHEET METAL WORKERS' NATIONAL HEALTH FUND
P.O. Box 1449
Goodlettsville, TN 37070-1449
Phone (615) 859-0131 Toll-free (800) 831-4914

Claim No. **1535299**

Check No. **0058078**

Explanation of Benefits

SMW+ Program

Dates of Service From	To	Amount Charged	Not Covered	Charges Allowed	Covered MajMed	MajMed Paid
12/29/2000	12/29/2000	$57.00	$0.00	$4.54	$4.54	$4.54
Total		$57.00	$0.00	$4.54	$4.54	$4.54

Comments:

REDACTED

Payment Sent To

SULLIVAN, FREDERICK
221 RICHMOND ST
NEW BEDFORD, MA 02740

Participant SSN:
MPC Claim Number: 1535299

Processed by *Southern Benefit Administrators, Inc.*

Medicare Summary Notice

January 29, 2001

REDACTED

FREDERICK J SULLIVAN
221 RICHMOND ST
NEW BEDFORD MA 02740-5620

CUSTOMER SERVICE INFORMATION

If you have questions, write or call:
National Heritage Insurance Company
P.O. Box 1000
Hingham, MA 02044

Local: (781) 741-3300
Toll-free: 1-800-882-1228
TTY For Hearing Impaired: 1-800-559-0443

HELP STOP FRAUD: Always review your Medicare Summary Notice for correct information about the items or services you received.

This is a summary of claims processed from 01/02/2001 through 01/26/2001.

PART B MEDICAL INSURANCE - ASSIGNED CLAIMS

Dates of Service	Services Provided	Amount Charged	Medicare Approved	Medicare Paid Provider	You May Be Billed	See Notes Section
Claim number 01-00356-057-390						
Andrew J Dadagian Md In, C, Roman House Annex, 386 County St, New Bedford, MA 02740-4932						
Dr. Dadagian, Andrew J. M.D.						
12/11/00	1 Remove impacted ear wax (69210)	$80.00	$51.21	$40.97	$10.24	
Claim number 02-01011-460-700						
Hawthorn Medical Associ, P.O. Box 3076, Boston, MA 02241-0001						
Dr. Charnond, Siroth M.D.						
11/22/00	4 Methotrexate sodium inj (J9260)	$24.00	$18.04	$14.43	$3.61	a
11/22/00	1 Injection, sc/im (90782)	33.00	4.66	3.73	0.93	
Claim Total		$57.00	$22.70	$18.16	$4.54	

MP 9-12

PMED34
0B1800
VER1

THIS IS NOT A BILL - Keep this notice for your records.

PART B MEDICAL INSURANCE - ASSIGNED CLAIMS (continued)

REDACTED

Dates of Service	Services Provided	Amount Charged	Medicare Approved	Medicare Paid Provider	You May Be Billed	See Notes Section
Claim number 02-00356-544-050						
Hawthorn Medical Associ, P.O. Box 3076, Boston, MA 02241-0001						
Dr. Egan, Michael W. M.D.						
12/13/00	1 Flu vaccine, 3 yrs, im (90658)	$25.00	$4.92	$4.92	$0.00	b
12/13/00	1 Admin influenza virus vac (G0008)	8.00	4.66	4.66	0.00	b
12/13/00	4 Methotrexate sodium inj (J9260)	24.00	18.04	14.43	3.61	a
12/13/00	1 Injection, sc/im (90782)	33.00	0.00	0.00	0.00	c,a
Claim Total		**$90.00**	**$27.62**	**$24.01**	**$3.61**	
Claim number 02-00363-395-520						
Hawthorn Medical Associ, P.O. Box 3076, Boston, MA 02241-0001						
Dr. Davidson, Gail M.D.						
12/20/00	4 Methotrexate sodium inj (J9260)	$24.00	$18.04	$14.43	$3.61	a
12/20/00	1 Injection, sc/im (90782)	33.00	4.66	3.73	0.93	
Claim Total		**$57.00**	**$22.70**	**$18.16**	**$4.54**	
Claim number 02-01011-456-170						
Hawthorn Medical Associ, P.O. Box 3076, Boston, MA 02241-0001						
Dr. Egan, Michael W. M.D.						
12/29/00	4 Methotrexate sodium inj (J9260)	$24.00	$18.04	$14.43	$3.61	a
12/29/00	1 Injection, sc/im (90782)	33.00	4.66	3.73	0.93	
Claim Total		**$57.00**	**$22.70**	**$18.16**	**$4.54**	
Claim number 02-01018-441-100						
Hawthorn Medical Associ, P.O. Box 3076, Boston, MA 02241-0001						
Dr. Egan, Michael W. M.D.						
01/05/01	1 Injection, sc/im (90782)	$33.00	$4.96	$0.00	$4.96	d

PLEASE DO NOT STAPLE IN THIS AREA

SHEET METAL WORKERS
PO BOX 1449

GOODLETTSVILLE TN 37070

EOB ATTACHED

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [X] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY: 03 21 1937 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street) REDACTED

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street) REDACTED

CITY: AGAWAM STATE: MA

8. PATIENT STATUS: Single [ ] Married [X] Other [ ]

CITY: AGAWAM STATE: MA

ZIP CODE: 01001 TELEPHONE (Include Area Code)

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: 01001 TELEPHONE (INCLUDING AREA CODE)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) REDACTED

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 03 21 1937 SEX M [X] F [ ]

5. OTHER INSURED'S DATE OF BIRTH MM DD YY: 03 21 1937 SEX M [X] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICARE OF MA

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO [ ] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: DAVID CHADBOURNE MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: B99559

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 198.5
2. 285.9
3. 787.02
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 12162004	12162004	11	1	90780	59	1	165.00	1				043499715
2 12162004	12162004	11	1	96410	59	1	300.00	1				043499715
3 12162004	12162004	11	1	J1100		1	50.00	10				043499715
4 12162004	12162004	11	1	Q0136		2	1800.00	60				043499715
5 12162004	12162004	11	1	J1626		3	400.00	10				043499715
6 12162004	12162004	11	1	J9293		1	3850.00	5				043499715

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]: 043499715

26. PATIENT'S ACCOUNT NO.: 288260

27. ACCEPT ASSIGNMENT? (For govt. claims see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 6565.00

29. AMOUNT PAID: $ 5997.81

30. BALANCE DUE: $ 567.19

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

PHILIP T GLYNN MD
SIGNED 01/25/2005 DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

GLYNN AND MURRAY OFFICE
299 CAREW STREET, STE 400
SPRINGFIELD MA 01104

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # 978 289-1189

GLYNN & MURRAY, PC
PO BOX 3160
ANDOVER MA 01810

PIN # GRP # 043499715

CARRIER

CARRIER PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE

1/19/DMH2 1/19 DeP

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215 FORM OWCP-1500, APPROVED OMB-0720-001 (CHAMPUS)

NATIONAL HERITAGE INSURANCE COMPANY
PROVIDER #: M20896
CHECK/EFT #:128186567 01/10/05

128186567 100001361
MURRAY AND GLYNN PC
PAGE #: 2 OF 3

MEDICARE REMITTANCE NOTICE

PERF PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
[redacted]											
					CLAIM TOTALS	100.00	55.97	0.00	11.19 CO-42	44.03	44.78
PT RESP 11.19											44.78 NET
[redacted]											
PT RESP 11.19					CLAIM TOTALS	100.00	55.97	0.00	11.19 CO-42	44.03	44.78
											44.78 NET
[redacted]											
						16.00	10.10	0.00	0.00 CO-42	5.90	10.10
						24.00	10.01	0.00	0.00 CO-42	13.99	10.01
PT RESP					CLAIM TOTALS	140.00	76.08	0.00	11.19	63.92	64.89
CLAIM INFORMATION FORWARDED TO: METLIFE INS. CO											64.89 NET
[redacted]											
J09882	1220	122004	11	1	99213	100.00	55.97	0.00	11.19 CO-42	44.03	44.78
J09882	1220	122004	11	1	93000	60.00	28.81	0.00	5.76 CO-42	31.19	23.05
PT RESP	16.95				CLAIM TOTALS	160.00	84.78	0.00	16.95	75.22	67.83
CLAIM INFORMATION FORWARDED TO: METLIFE INS. CO											67.83 NET
[redacted]						ACNT 288280			ICN 020436207410O	ASG Y	MOA MA01
J08093	1216	121604	11			165.00	130.86	0.00	26.17 CO-42	34.14	104.69
J08093	1216	121604	11		59	35.00	0.00	0.00	0.00 CO-815	35.00	0.00
J08093	1216	121604	11		59	300.00	243.10	0.00	48.62 CO-42	56.90	194.48
J08093	1216	121604	11	10	J1100	50.00	1.00	0.00	0.20 CO-42	49.00	0.80
J08093	1216	121604	11	60	QD136	1800.00	697.20	0.00	139.44 CO-42	1102.80	557.76
J08093	1216	121604	11	10	J1626	400.00	156.20	0.00	31.24 CO-42	243.80	124.96
J08093	1216	121604	11	5	J9293	3850.00	1607.60	0.00	321.52 CO-42	2242.40	1286.08
J08093	1216	121604	11	3	J7040	45.00	16.92	0.00	3.38 CO-42	28.08	13.54
PT RESP 570.57					CLAIM TOTALS	6645.00	2852.88	0.00	570.57	3792.12	2282.31
											2282.31 NET
[redacted]											
PT RESP 11.19					CLAIM TOTALS	100.00	55.97	0.00	11.19	44.03	44.78
											44.78 NET
[redacted]											
PT RESP					CLAIM TOTALS	150.00	87.24	0.00	17.45	62.76	69.79
CLAIM INFORMATION FORWARDED TO: UNICARE											69.79 NET

PLEASE DO NOT STAPLE IN THIS AREA

SHEET METAL WORKERS
PO BOX 1449

GOODLETTSVILLE TN 37070

EOB ATTACHED

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE	MEDICAID	CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
						X

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

REDACTED

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY — SEX

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

REDACTED

5. PATIENT'S ADDRESS (No., Street)

REDACTED

6. PATIENT RELATIONSHIP TO INSURED: Self X | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY	STATE
AGAWAM	MA

8. PATIENT STATUS: Single | Married X | Other

CITY	STATE
AGAWAM	MA

ZIP CODE	TELEPHONE (Include Area Code)
01001	

Employed | Full-Time Student | Part-Time Student

ZIP CODE	TELEPHONE (INCLUDING AREA CODE)
01001	

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

REDACTED

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES | X NO

a. INSURED'S DATE OF BIRTH MM DD YY: 03 21 1937 — SEX M X | F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX

b. AUTO ACCIDENT? YES | X NO — PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | X NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICARE OF MA

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? X YES | NO — If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE — DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY — FROM — TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: DAVID CHADBOURNE MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: B99559

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY — FROM — TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | X NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 185
2.
3.
4.

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 12 14 2004	12 14 2004	11	1	99213		1	100 00	1				043499715
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
043499715		X	282550	X YES NO	$ 100.00	$ 88.81	$ 11.19

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

PHILIP T GLYNN MD

SIGNED 01/13/2005 DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

GLYNN AND MURRAY OFFICE
299 CAREW STREET, STE 400
SPRINGFIELD MA 01104

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # 978 289-1189

GLYNN & MURRAY, PC
PO BOX 3160
ANDOVER MA 01810

PIN # — GRP # 043499715

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215 FORM OWCP-1500, APPROVED OMB-0720-001 (CHAMPUS)

CARRIER

CARRIER PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NATIONAL HERITAGE INSURANCE COMPANY
PROVIDER #: M20895
CHECK/EFT #:128168637 01/03/05

128168637 100001247
MURRAY AND GLYNN PC
PAGE #: 4 OF 6

MEDICARE REMITTANCE NOTICE

PERF PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
[redacted]											
J09682	1216 121504	11	1	93000		60.00	28.81	0.00	5.76 CO-42	31.19	23.05
J09682	1216 121504	11	1	82270		15.00	4.54	0.00	0.00 CO-42	10.46	4.54
PT RESP	23.21			CLAIM TOTALS		225.00	120.59	0.00	23.21	104.41	97.38
											97.38 NET
[redacted]											
J08093	1216 121604	11	1	99214		150.00	87.24	0.00	17.45 CO-42	62.76	69.79
PT RESP	17.45			CLAIM TOTALS		150.00	87.24	0.00	17.45	62.76	69.79
CLAIM INFORMATION FORWARDED TO: NAT ASSOC OF LETTER CARRIER											69.79 NET
[redacted]											
PT RESP	17.45			CLAIM TOTALS		150.00	87.24	0.00	17.45	62.76	69.79
											69.79 NET
[redacted]											
PT RESP	17.45			CLAIM TOTALS		150.00	87.24	0.00	17.45 CO-42	62.76	69.79
											69.79 NET
[redacted]											
						ACWT 282550			ICN 0204356042460	ASG Y HOA HA01	
[redacted]						100.00	55.97	0.00	11.19 CO-42	44.03	44.78
[redacted]				CLAIM TOTALS		100.00	55.97	0.00	11.19	44.03	44.78
											44.78 NET
[redacted]											
J09682	1215 121504	11	1	99214		150.00	87.24	0.00	17.45 CO-42	62.76	69.79
J09682	1215 121504	11	1	93000		60.00	28.81	0.00	5.76 CO-42	31.19	23.05
J09682	1215 121504	11	1	94760		20.00	0.00	0.00	0.00 CO-B15	20.00	0.00
PT RESP	23.21			CLAIM TOTALS		230.00	116.05	0.00	23.21	113.95	92.84
CLAIM INFORMATION FORWARDED TO: METLIFE INS. CO											92.84 NET
[redacted]											
J09682	1216 121604	11	1	60008		24.00	10.01	0.00	0.00 CO-42	13.99	10.01
PT RESP	0.00			CLAIM TOTALS		40.00	20.11	0.00	0.00	19.89	20.11
											20.11 NET
[redacted]											
PT RESP	11.19			CLAIM TOTALS		100.00	55.97	0.00	11.19	44.03	44.78
											44.78 NET
[redacted]											
PT RESP	17.45			CLAIM TOTALS		150.00	87.24	0.00	17.45	62.76	69.79
											69.79 NET
[redacted]											
J08093	1214 121404	11	1	99213		100.00	55.97	0.00	11.19	44.03	44.78
PT RESP	11.19			CLAIM TOTALS		100.00	55.97	0.00	11.19	44.03	44.78
											44.78 NET
[redacted]											
PT RESP	11.19			CLAIM TOTALS		100.00	55.97	0.00	11.19	44.03	44.78
											44.78 NET
[redacted]											
J09682	1215 121504	11	1	99211		40.00	23.15	0.00	4.63 CO-42	16.85	18.52
PT RESP	4.63			CLAIM TOTALS		40.00	23.15	0.00	4.63	16.85	18.52
											18.52 NET
[redacted]											
J08093	1214 121404	11	1	90658		16.00	10.10	0.00	0.00 CO-42	5.90	10.10
J08093	1214 121404	11	1	90471		24.00	0.00	0.00	0.00 PR-49	24.00	0.00
J08093	1214 121404	11	1	90782 59		35.00	26.66	0.00	5.33 CO-42	8.34	21.33
J08093	1214 121404	11	60	J0880		2460.00	1272.00	0.00	254.40 CO-42	1188.00	1017.60
PT RESP	283.73			CLAIM TOTALS		2535.00	1308.76	0.00	259.73	1226.24	1049.03
											1049.03 NET

PLEASE DO NOT STAPLE IN THIS AREA

SHEET METAL WORKERS
PO BOX 1449

GOODLETTSVILLE TN 37070

EOB ATTACHED

CARRIER

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [X] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY: 03 21 1937 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial) REDACTED

5. PATIENT'S ADDRESS (No., Street) REDACTED

6. PATIENT RELATIONSHIP TO INSURED Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street) REDACTED

CITY: AGAWAM STATE: MA

8. PATIENT STATUS Single [ ] Married [X] Other [ ]
Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: AGAWAM STATE: MA

ZIP CODE: 01001 TELEPHONE (Include Area Code) (

ZIP CODE: 01001 TELEPHONE (INCLUDING AREA CODE)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER REDACTED

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 03 21 1937 SEX M [X] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: 03 21 1937 SEX M [X] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICARE OF MA

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [X] YES [ ] NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

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15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: DAVID CHADBOURNE MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: B99559

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 285.9
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 12092004	12092004	11	1	90782		1	35 00	1				043499715
2 12092004	12092004	11	1	Q0136		1	1200 00	40				043499715
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER: 043499715 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 281050

27. ACCEPT ASSIGNMENT? (For govt. claims see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 1235 00

29. AMOUNT PAID: $ 1136 71

30. BALANCE DUE: $ 98 29

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

PHILIP T GLYNN MD
SIGNED 01/13/2005 DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

GLYNN AND MURRAY OFFICE
299 CAREW STREET, STE 400
SPRINGFIELD MA 01104

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # 978 289 1189

GLYNN & MURRAY, PC
PO BOX 3160
ANDOVER MA 01810

PIN # GRP # 043499715

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE

11/7 IMH 11/6 DEP

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215 FORM OWCP-1500, APPROVED OMB-0720-001 (CHAMPUS)

NATIONAL HERITAGE INSURANCE COMPANY
PROVIDER #: MZ0895
CHECK/EFT #:128156460 12/28/04

128156460 100000821
HURRAY AND GLYNN PC
PAGE #: 2 OF 3

MEDICARE REMITTANCE NOTICE

PERF PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
[redacted]			1	90782		35.00	26.66	0.00	5.33 CO-42	8.34	21.33
J08093	1210 121004	11	40	00136		1200.00	464.80	0.00	92.96 CO-42	735.20	371.84
PT RESP	58.29				CLAIM TOTALS	1235.00	491.46	0.00	98.29	743.54	393.17
											393.17 NET
[redacted]			1	99214		150.00	87.24	0.00	17.45 CO-42	62.76	69.79
PT RESP	17.45				CLAIM TOTALS	150.00	87.24	0.00	17.45		69.79
CLAIM INFORMATION FORWARDED TO: METLIFE INS. CO											69.79 NET
J08093	1210 121004	11	1	99214		150.00	87.24	0.00	17.45 CO-42	62.76	69.79
PT RESP	17.45				CLAIM TOTALS	150.00	87.24	0.00	17.45	62.76	69.79
											69.79 NET
[redacted]											B
J08093	1209 120904	11	1	90782		35.00	26.66	0.00	5.33 CO-42		
J08093	1209 120904	11	40	00136		1200.00	464.80	0.00	92.96 CO-42	735.20	371.84
[redacted]	98.29				CLAIM TOTALS	1235.00	491.46	0.00	98.29	743.54	393.17
[redacted] FORWARDED TO: [redacted] OF ALABAMA											393.17 NET
J08093	1209 120904	11			ACNT 281050	35.00	26.66	0.00	ICN 0204351043780 5.33 CO-42	ASG Y MOA MA01 8.34	21.33
J08093	1209 120904	11	40	00136		1200.00	464.80	0.00	92.96 CO-42	735.20	371.84
PT RESP	98.29				CLAIM TOTALS	1235.00	491.46	0.00	98.29	743.54	393.17
											393.17 NET
[redacted]											
PT RESP	17.45		1	99214	CLAIM TOTALS	150.00	87.24	0.00	17.45 CO-42	62.76	69.79
											69.79 NET
[redacted]										MA18	
J09682	1210 121004	11	1	99214		150.00	87.24	0.00	17.45 CO-42	62.76	69.79
J09682	1210 121004	11	1	93000		60.00	28.81	0.00	5.76 CO-42	31.19	23.05
J09682	1210 121004	11	1	82270		15.00	4.54	0.00	0.00 CO-42	10.46	4.54
PT RESP	23.21				CLAIM TOTALS	225.00	120.59	0.00	23.21	104.41	97.38
											97.38 NET

REDACTED

[redacted]

PLEASE DO NOT STAPLE IN THIS AREA

SHEET METAL WORKERS
PO BOX 1449

GOODLETTSVILLE TN 37070

EOB ATTACHED

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	CHAMPUS (Sponsor's SSN)	CHAMPVA (VA File #)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER X (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) REDACTED

3. PATIENT'S BIRTH DATE MM DD YY: 03 21 1937 SEX M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial) REDACTED

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY: AGAWAM STATE: MA

8. PATIENT STATUS: Single Married X Other; Employed Full-Time Student Part-Time Student

CITY: AGAWAM STATE: MA

ZIP CODE: 01001 TELEPHONE (Include Area Code)

ZIP CODE: 01001 TELEPHONE (INCLUDING AREA CODE)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) REDACTED

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO X

a. INSURED'S DATE OF BIRTH MM DD YY: 03 21 1937 SEX M X F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: 03 21 1937 SEX M X F

b. AUTO ACCIDENT? YES NO X PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO X

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICARE OF MA

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? X YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY — ILLNESS (First Symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: DAVID CHADBOURNE MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: B99559

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES X NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 285.9
2. 185.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 07012004	07012004	11	1	90782		1,2	35.00	1				043499715
2 07012004	07012004	11	1	Q0136		1,2	1200.00	40				043499715
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN: 043499715 X

26. PATIENT'S ACCOUNT NO.: 213290

27. ACCEPT ASSIGNMENT? (For govt. claims see back) X YES NO

28. TOTAL CHARGE: $ 1235.00

29. AMOUNT PAID: $ 1136.71

30. BALANCE DUE: $ 98.29

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

PHILIP T GLYNN MD

SIGNED 03/08/2005 DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

GLYNN AND MURRAY OFFICE
299 CAREW STREET, STE 400
SPRINGFIELD MA 01104

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # 978 289-1189

GLYNN & MURRAY, PC
PO BOX 3160
ANDOVER MA 01810

PIN # GRP # 043499715

CARRIER

CARRIER PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215 FORM OWCP-1500, APPROVED OMB-0720-001 (CHAMPUS)

10/4 No

NATIONAL HERITAGE INSURANCE COMPANY
PROVIDER #: M20895
CHECK/EFT #:127905604 09/28/04

127905604 100000782
MURRAY AND GLYNN PC
PAGE #: 3 OF 5

MEDICARE REMITTANCE NOTICE

PERF PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
[redacted]											
	0910 091004 11	1		93000		60.00	28.81	0.00	5.76 CO-42	31.19	23.05
PT RESP 16.95				CLAIM TOTALS		160.00	84.78	0.00	16.95	75.22	67.83
											67.83 NET
[redacted]						150.00	87.24	0.00	17.45 CO-42	62.76	69.79
J09682	0910 091004 11	1		93000		60.00	28.81	0.00	5.76 CO-42	31.19	23.05
PT RESP 23.21				CLAIM TOTALS		210.00	116.05	0.00	23.21	93.95	92.84
											92.84 NET
[redacted]											
	0908 090804 22	1		99213		100.00	36.58	0.00	7.32 CO-B6	63.42	29.26
PT RESP 7.32				CLAIM TOTALS		100.00	36.58	0.00	7.32	63.42	29.26
CLAIM INFORMATION FORWARDED TO: BC/BS OF MASS											29.26 NET
[redacted]											
	0910 091004 11	1		99214		150.00	87.24	0.00	17.45 CO-42	62.76	69.79
PT RESP 17.45				CLAIM TOTALS		150.00	87.24	0.00	17.45	62.76	69.79
CLAIM INFORMATION FORWARDED TO: BC/BS OF MASS											69.79 NET
[redacted]											
		1		99213		100.00	55.97	0.00	11.19 CO-42	44.03	44.78
PT RESP 11.19				CLAIM TOTALS		100.00	55.97	0.00	11.19	44.03	44.78
CLAIM INFORMATION FORWARDED TO: JOHN HANCOCK											44.78 NET
[redacted]											
	0910 091004 11	1		99214		150.00	87.24	0.00	17.45 CO-42	62.76	69.79
PT RESP 17.45				CLAIM TOTALS		150.00	87.24	0.00	17.45	62.76	69.79
											69.79 NET
[redacted]											
	0908 090804 22	1		99213		100.00	36.58	0.00	7.32 CO-B6	63.42	29.26
PT RESP 7.32				CLAIM TOTALS		100.00	36.58	0.00	7.32	63.42	29.26
CLAIM INFORMATION FORWARDED TO: MPS-TRICARE											29.26 NET
[redacted]											
PT RESP 7.32	0908 090804 22	1		99213		100.00	36.58	0.00	7.32	63.42	29.26
				CLAIM TOTALS		100.00	36.58	0.00	7.32	63.42	29.26
											29.26 NET
[redacted]											
PT RESP 11.19	0910 091004 11	1		99213		100.00	55.97	0.00	11.19 CO-42	44.03	44.78
CLAIM INFORMATION FORWARDED TO: BC/BS OF ALABAMA				CLAIM TOTALS		100.00	55.97	0.00	11.19	44.03	44.78
											44.78 NET
[redacted]											
PT RESP 11.19	0910 091004 11	1		99213		100.00	55.97	0.00	11.19 CO-42	44.03	44.78
CLAIM INFORMATION FORWARDED TO: BC/BS OF MASS				CLAIM TOTALS		100.00	55.97	0.00	11.19	44.03	44.78
											44.78 NET
[redacted]											
009682	0910 091004 11	1		93000		60.00	28.81	0.00	5.76 CO-42	31.19	23.05
PT RESP 16.95				CLAIM TOTALS		160.00	84.78	0.00	16.95	75.22	67.83
CLAIM INFORMATION FORWARDED TO: JOHN HANCOCK											67.83 NET
[redacted]											
PT RESP 7.32	0908 090804 22	1		99213		100.00	36.58	0.00	7.32	63.42	29.26
				CLAIM TOTALS		100.00	36.58	0.00	7.32	63.42	29.26
CLAIM INFORMATION FORWARDED TO: AARP											29.26 NET
REDACTED					ACHT 213290				ICN 0204260054720	ASG Y NOA MA01	
J08093	0701 070104 11	40		00136		35.00	26.66	0.00	5.33 CO-42	8.34	21.33
PT RESP 98.29				CLAIM TOTALS		1200.00	464.80	0.00	92.96 CO-42	735.20	371.84
						1235.00	491.46	0.00	98.29	743.54	393.17
											393.17 NET
[redacted]											
	0908 090804 22	1		99213		100.00	36.58	0.00	7.32 CO-B6	63.42	29.26
PT RESP 7.32				CLAIM TOTALS		100.00	36.58	0.00	7.32	63.42	29.26
CLAIM INFORMATION FORWARDED TO: XPS-TRICARE											29.26 NET

PLEASE DO NOT STAPLE IN THIS AREA

SHEET METAL WORKERS
PO BOX 1449

GOODLETTSVILLE TN 37070

BOB ATTACHED

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [X] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY 03 21 1937 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial) REDACTED

5. PATIENT'S ADDRESS (No., Street) REDACTED

6. PATIENT RELATIONSHIP TO INSURED Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY AGAWAM STATE MA

8. PATIENT STATUS Single [ ] Married [X] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY AGAWAM STATE MA

ZIP CODE 01001 TELEPHONE (Include Area Code) (

ZIP CODE 01001 TELEPHONE (INCLUDING AREA CODE)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER REDACTED

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY 03 21 1937 SEX M [X] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY 03 21 1937 SEX M [X] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME MEDICARE OF MA

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO [ ] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE DAVID CHADBOURNE MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN B99559

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. L285.9
2. L185
3. L
4. L

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 02102005	02102005	11	1	G0351		1,2	38.00	1				043499715
2 02102005	02102005	11	1	Q0136		1,2	1800.00	60				043499715
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X] 043499715

26. PATIENT'S ACCOUNT NO. 308230

27. ACCEPT ASSIGNMENT? (For govt. claims see back) YES [X] NO [ ]

28. TOTAL CHARGE $ 1838.00

29. AMOUNT PAID $ 1711.74

30. BALANCE DUE $ 126.26

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

PHILIP T GLYNN MD

SIGNED 03/08/2005 DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

GLYNN AND MURRAY OFFICE
299 CAREW STREET, STE 400
SPRINGFIELD MA 01104

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # 978 289-1189

GLYNN & MURRAY, PC
PO BOX 3160
ANDOVER MA 01810

PIN # GRP # 043499715

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

317 DeP

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215 FORM OWCP-1500, APPROVED OMB-0720-001 (CHAMPUS)

CARRIER

CARRIER PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NATIONAL HERITAGE INSURANCE COMPANY
PROVIDER #: M20895
CHECK/EFT #:128300543 02/28/05

128300543 100001294
MURRAY AND GLYNN PC
PAGE #: 5 OF 8

MEDICARE REMITTANCE NOTICE

PERF PROV	SERV DATE	POS MOS	PROC	MODS					PROV PD
[redacted]									
PT RESP 11.15	0210 021005 11	1	99213	CLAIM TOTALS	111.00 111.00	55.74 55.74	0.00 0.00	11.15 CO-42 11.15	55.26 55.26	44.59 44.59 NET
[redacted]									
J08093	0202 020205 22	1	99211 25		47.00	9.35	0.00	1.87 CO-86	37.65	
J08093	0202 020205 22	1	38220 5951		401.00	82.58	0.00	6.52 CO-86	335.84	26.06
								CO-59	32.58	
J08093	0202 020205 22	1	38221 59		442.00	82.06	0.00	16.41 CO-86	359.94	65.65
PT RESP 24.80				CLAIM TOTALS	890.00	123.99	0.00	24.80	766.01	99.19 NET
[redacted]										
J08093	0208 020805 11	1	99213		111.00	55.74	0.00	11.15 CO-42	WA18 55.26	44.59
PT RESP 11.15				CLAIM TOTALS	111.00	55.74	0.00	11.15	55.26	44.59
CLAIM INFORMATION FORWARDED TO: BC/BS OF ALABAMA										44.59 NET
[redacted]					ACNT 308230			ICN 02050470595OO	ASG Y MOA MA01	
J08093	0102 010205 21	1	99223		38.00	20.52	0.00	4.10 CO-42	17.48	16.42
J08093	0102 010205 21	1	[redacted]		1800.00	610.80	0.00	122.16 CO-42	1189.20	488.64
PT RESP 126.26				CLAIM TOTALS	1838.00	631.32	0.00	126.26	1206.68	505.06
										505.06 NET
[redacted]										
J08093	0102 010205 21	1	99223		250.00	161.95	0.00	32.39 CO-42	88.06	129.56
PT RESP 32.39				CLAIM TOTALS	250.00	161.95	0.00	32.39	88.06	129.56 NET
[redacted]										
J08093	0210 021005 11	1	99214		174.00	87.18	0.00	17.44 CO-42	86.82	69.74
PT RESP 17.44				CLAIM TOTALS	174.00	87.18	0.00	17.44	86.82	69.74 NET
[redacted]										
J08093	0209 020905 22	1	99214		174.00	60.96	0.00	12.19 CO-86	113.04	48.77
PT RESP 12.19				CLAIM TOTALS	174.00	60.96	0.00	12.19	113.04	48.77 NET
CLAIM INFORMATION FORWARDED TO: WPS-TRICARE										
[redacted]										
J09682	0208 020805 11	1	99213		111.00	55.74	55.74	0.00 CO-42	55.26	0.00
J09682	0208 020805 11	1	90732		47.00	23.28	0.00	0.00 CO-42	23.72	23.28
J09682	0208 020805 11	1	90009		40.00	22.07	0.00	0.00 CO-42	17.93	22.07
PT RESP 55.74				CLAIM TOTALS	198.00	101.09	55.74	0.00	96.91	45.35
										45.35 NET
[redacted]										
PT RESP 12.19				CLAIM TOTALS	174.00	60.96	0.00	12.19	113.04	48.77
CLAIM INFORMATION FORWARDED TO: WPS-TRICARE										48.77 NET
[redacted]										
J08093	0208 020805 11	1	99214		174.00	87.18	54.26	6.58 CO-42	86.82	26.34
PT RESP 60.84				CLAIM TOTALS	174.00	87.18	54.26	6.58	86.82	26.34 NET
[redacted]										
J08093	0210 021005 11	1	80360		80.00	43.27	0.00	8.65 CO-42	36.73	34.62
J08093	0210 021005 11	1	80362		173.00	95.03	0.00	19.01 CO-42	77.97	76.02
J08093	0210 021005 11	1	89021		43.34	43.34	0.00	8.67		34.67
J08093	0210 021005 11	1	89025		43.33	43.33	0.00	8.67		34.66
J08093	0210 021005 11	1	89030		43.33	43.33	0.00	8.67		34.66
J08093	0210 021005 11	50	J9035		5700.00	2854.00	0.00	570.80 CO-42	2846.00	2283.20
J08093	0210 021005 11	10	J1100		10.00	1.40	0.00	0.28 CO-42	8.60	1.12
J08093	0210 021005 11	40	Q0136		1200.00	407.20	0.00	81.44 CO-42	792.80	325.76
J08093	0210 021005 11	2	J9190		6.00	3.36	0.00	0.67 CO-42	2.64	2.69
J08093	0210 021005 11	10	J1626		400.00	70.90	0.00	14.18 CO-42	329.10	56.72
J08093	0210 021005 11	9	J9206		2880.00	1130.22	0.00	226.04 CO-42	1749.78	904.18
J08093	0210 021005 11	1	J0640		15.00	1.30	0.00	0.26 CO-42	13.70	1.04
J08093	0210 021005 11	4	J7040		60.00	0.20	0.00	0.04 CO-42	59.80	0.16
PT RESP 947.38				CLAIM TOTALS	10654.00	4736.88	0.00	947.38	5917.12	3789.50
CLAIM INFORMATION FORWARDED TO: UNICARE										3789.50 NET

REDACTED

PLEASE DO NOT STAPLE IN THIS AREA

SHEET METAL WORKERS
PO BOX 1449

GOODLETTSVILLE TN 37070

EOB ATTACHED

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [X] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY: 03 21 1937 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial) REDACTED

5. PATIENT'S ADDRESS (No., Street) REDACTED

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: AGAWAM STATE: MA

8. PATIENT STATUS: Single [ ] Married [X] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: AGAWAM STATE: MA

ZIP CODE: 01001 TELEPHONE (Include Area Code)

ZIP CODE: 01001 TELEPHONE (INCLUDING AREA CODE)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) REDACTED

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 03 21 1937 SEX M [X] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: 03 21 1937 SEX M [X] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICARE OF MA

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO [ ] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: DAVID CHADBOURNE MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: B99559

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 285.9 3. 2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 02032005	02032005	11	1	00136		1	1800.00	60				043499715
2 02032005	02032005	11	1	G0351		1	38.00	1				043499715
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER: 043499715 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 305160

27. ACCEPT ASSIGNMENT? (For govt. claims see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 1838.00

29. AMOUNT PAID: $ 1711.74

30. BALANCE DUE: $ 126.26

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

PHILIP T GLYNN MD

SIGNED 03/08/2005 DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

GLYNN AND MURRAY OFFICE
299 CAREW STREET, STE 400
SPRINGFIELD MA 01104

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # 978 289-1189

GLYNN & MURRAY, PC
PO BOX 3160
ANDOVER MA 01810

PIN # GRP # 043499715

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER PATIENT AND INSURED INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

3/1 Dep

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215 FORM OWCP-1500, APPROVED OMB-0720-001 (CHAMPUS)

NATIONAL HERITAGE INSURANCE COMPANY
PROVIDER #: H20895
CHECK/EFT #: 128289075 02/22/05

128289075 100001078
MURRAY AND GLYNN PC
PAGE #: 3 OF 4

MEDICARE REMITTANCE NOTICE

PERF PROV SERV DATE POS NOS PROC MODS BILLED ALLOWED DEDUCT COINS GRP/RC-AMT PROV PD

[redacted]
PT RESP 17.44 CLAIM TOTALS 174.00 87.18 0.00 17.44 86.82 69.74
69.74 NET
CLAIM INFORMATION FORWARDED TO: BC/BS OF ALABAMA

ACNT 305160 ICN 0205040049720 ASG Y MOA MA01
REDACTED 1800.00 610.80 0.00 122.16 CO-42 1189.20 488.64
60351 38.00 20.52 0.00 4.10 CO-42 17.48 16.42
CLAIM TOTALS 1838.00 631.32 0.00 126.26 1206.68 505.06
505.06 NET

[redacted]
PT RESP 17.44 CLAIM TOTALS 174.00 87.18 0.00 17.44 86.82 69.74
69.74 NET

[redacted]
PT RESP 25.72 CLAIM TOTALS 257.00 128.61 0.00 25.72 128.39 102.89
102.89 NET
CLAIM INFORMATION FORWARDED TO: UNICARE

[redacted]
PT RESP 48.62 CLAIM TOTALS 300.00 243.10 0.00 48.62 56.90 194.48
194.48 NET
CLAIM INFORMATION FORWARDED TO: UNICARE

[redacted]
309682 0203 020306 11 1 99214 174.00 87.18 0.00 17.44 CO-42 86.82
PT RESP 17.44 CLAIM TOTALS 174.00 87.18 0.00 17.44 86.82 69.74
69.74 NET

[redacted]
PT RESP 17.44 CLAIM TOTALS 174.00 87.18 0.00 17.44 86.82 69.74
69.74 NET

[redacted]
PT RESP 11.15 CLAIM TOTALS 111.00 55.74 0.00 11.15 55.26 44.59
44.59 NET

[redacted]
PT RESP 55.74 CLAIM TOTALS 111.00 55.74 55.74 0.00 55.26 0.00
0.00 NET

[redacted]
REM: M51
PT RESP 0.00 CLAIM TOTALS 14.00 0.00 0.00 0.00 14.00 0.00
0.00 NET

[redacted]
REM: M51
PT RESP 0.00 CLAIM TOTALS 14.00 0.00 0.00 0.00 14.00 0.00
0.00 NET

[redacted]
REM: M51
PT RESP 0.00 CLAIM TOTALS 14.00 0.00 0.00 0.00 14.00 0.00
0.00 NET

[redacted]
J09682 0211 021105 11 1 94760 10.00 0.00 0.00 0.00 CO-B15 10.00 0.00
PT RESP 56.74 CLAIM TOTALS 121.00 55.74 55.74 0.00 66.26 0.00
0.00 NET

[redacted]
111.00 0.00 0.00 0.00 PR-31 111.00 0.00
CLAIM TOTALS 111.00 0.00 0.00 0.00 111.00 0.00
0.00 NET

REDACTED	Employee
04-3499715	288260

57

04/25/2005
Date Issued

Amount Paid: $98.29

REDACTED
AGAUAM, MA 01001

File Copy This is not a Check

SHEET METAL WORKERS' NATIONAL HEALTH FUND
P.O. Box 1449
Goodlettsville, TN 37070-1449
Phone (615) 859-0131 Toll-free (800) 831-4914

Claim No. **2876150**

Check No. **1399686**

Explanation of Benefits **SMW+ Program**

Dates of Service From	To	Amount Charged	Non-Covered	Charges Allowed	Covered Man/Med	Man/Med Paid
12/09/2004	12/09/2004	$1,235.00	$0.00	$98.29	$98.29	$98.29
	Total	$1,235.00	$0.00	$98.29	$98.29	$98.29

Comments:

REDACTED
MURRAY AND GLYNN PC
PO BOX 3160
ANDOVER, MA 01810

Provider: MURRAY AND GLYNN PC
Participant SSN: REDACTED Dependent: 01
RES Claim Number: 2876150

Processed by *Southern Benefit Administrators, Inc.*

57

EMPLOYER	[illegible]	[illegible]
REDACTED		Employee
[illegible]	[illegible]	
04-3499715	288260	

04/25/2005
Date Issued

Amount Paid: $11.19

REDACTED

File Copy This is not a Check

SHEET METAL WORKERS' NATIONAL HEALTH FUND
P.O. Box 1449
Goodlettsville, TN 37070-1449
Phone (615) 859-0131 Toll-free (800) 831-4914

Claim No. 2876149

Check No. 1399685

Explanation of Benefits SMW+ Program

Dates of Service From	To	Amount Charged	Non Covered	Charges Allowed	Covered Maj Med	Maj Med Paid
12/14/2004	12/14/2004	$100.00	$0.00	$11.19	$11.19	$11.19
Total		$100.00	$0.00	$11.19	$11.19	$11.19

Comments:

Provider: REDACTED
Participant SSN REDACTED 01
RES Claim Number: 2876149

Payment made to:

MURRAY AND GLYNN PC
PO BOX 3160
ANDOVER, MA 01810

Processed by *Southern Benefit Administrators, Inc.*

REDACTED

	Employee
04-3499715	288260

57

04/25/2005
Date Issued

Amount Paid: $126.26

REDACTED
AGAWAM, MA 01001

File Copy This is not a Check

SHEET METAL WORKERS' NATIONAL HEALTH FUND
P.O. Box 1449
Goodlettsville, TN 37070-1449
Phone (615) 859-0131 Toll-free (800) 831-4914

Claim No. **2876151**

Check No. **1399687**

Explanation of Benefits **SMW+ Program**

Dates of Service From	To	Amount Charged	Non-Covered	Charges Allowed	Covered Mat Med	Mat Med Paid
02/10/2005	02/10/2005	$1,838.00	$0.00	$126.26	$126.26	$126.26
Total		$1,838.00	$0.00	$126.26	$126.26	$126.26

Comments:

Payment Issued To:

MURRAY AND GLYNN PC
PO BOX 3160
ANDOVER, MA 01810

Provider: REDACTED MURRAY AND GLYNN PC
Participant SSN:
RES Claim Number: 2876151

01

Processed by *Southern Benefit Administrators, Inc.*

PLEASE DO NOT STAPLE IN THIS AREA

SHEET METAL WORKERS
PO BOX 1449

GOODLETTSVILLE TN 37070

EOB ATTACHED

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID) X

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) REDACTED

3. PATIENT'S BIRTH DATE MM DD YY 03 21 1937 | SEX M X | F

4. INSURED'S NAME (Last Name, First Name, Middle Initial) REDACTED

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self X | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY AGAWAM | STATE MA

8. PATIENT STATUS Single | Married X | Other
Employed | Full-Time Student | Part-Time Student

CITY AGAWAM | STATE MA

ZIP CODE 01001 | TELEPHONE (Include Area Code)

ZIP CODE 01001 | TELEPHONE (INCLUDING AREA CODE)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) REDACTED

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER A

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES | NO X

a. INSURED'S DATE OF BIRTH MM DD YY 03 21 1937 | SEX M X | F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY 03 21 1937 | SEX M X | F

b. AUTO ACCIDENT? YES | NO X | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO X

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME MEDICARE OF MA

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? X YES | NO | If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE DAVID CHADBOURNE MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN B99559

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | X NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. L185
2. 285.9
3. L787.02
4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 01072005	01072005	11	1	G0351		1	21.00	1				043499715
2 01072005	01072005	11	1	J1100		1	50.00	10				043499715
3 01072005	01072005	11	1	Q0136		2	1800.00	60				043499715
4 01072005	01072005	11	1	J1626		3	400.00	10				043499715
5 01072005	01072005	11	1	J9293		1	3850.00	5				043499715
6												

25. FEDERAL TAX I.D. NUMBER 043499715 | SSN | EIN X

26. PATIENT'S ACCOUNT NO. 292970

27. ACCEPT ASSIGNMENT? (For govt. claims see back) X YES | NO

28. TOTAL CHARGE $ 6121.00

29. AMOUNT PAID $ 5658.48

30. BALANCE DUE $ 462.52

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

PHILIP T GLYNN MD
SIGNED 02/24/2005 DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

GLYNN AND MURRAY OFFICE
299 CAREW STREET, STE 400
SPRINGFIELD MA 01104

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # 978 289-1189

GLYNN & MURRAY, PC
PO BOX 3160
ANDOVER MA 01810

PIN # GRP # 043499715

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215 FORM OWCP-1500, APPROVED OMB-0720-001 (CHAMPUS)

CARRIER

CARRIER PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

219 DEO

NATIONAL HERITAGE INSURANCE COMPANY
PROVIDER #: M20895
CHECK/EFT #:128242476 02/01/05

128242476 10000073B
MURRAY AND GLYNN PC
PAGE #: 2 OF 4

MEDICARE REMITTANCE NOTICE

PERF PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
[redacted]						160.00	80.51	22.82	11.54 CO-42	[redacted]	[redacted]
J08093	0110 011005	11	3	J2430		1665.00	177.18	0.00	35.44 CO-42	1487.82	141.74
J08093	0110 011005	11	1	J7040		15.00	0.05	0.00	0.01 CO-42	14.95	0.04
J08093	0110 011005	11	1	G0347		81.00	81.00	0.00	16.20		64.80
J08093	0110 011005	11	1	G0348		28.00	28.00	0.00	5.60		22.40
J08093	0110 011005	11	1	G0356		38.00	38.00	0.00	7.60		30.40
J08093	0110 011005	11	1	G9021		0.01	0.00	0.00	0.00 CO-107	0.01	0.00
J08093	0110 011005	11	1	G9025		0.01	0.00	0.00	0.00 CO-107	0.01	0.00
J08093	0110 011005	11	1	G9029		0.01	0.00	0.00	0.00 CO-107	0.01	0.00
PT RESP	99.21			CLAIM TOTALS		1987.03	404.74	22.82	76.39	1502.29	305.53
											305.53 NET

REDACTED

						ACNT 292970			1CR 0205020049890	ASG Y HOA HA01	
[redacted]						45.00	0.00	0.00	0.00 CO-107	45.00	0.00
J08093	0107 010705	11	1	G0351		21.00	20.52	0.00	4.10 CO-42	0.48	16.42
J08093	0107 010705	11	1	G0353		30.00	0.00	0.00	0.00 CO-B15	30.00	0.00
REM: M80											
J08093	0107 010705	11	1	G0359		182.00	0.00	0.00	0.00 CO-B13	182.00	0.00
REM: M86											
J08093	0107 010705	11	1	G9022		0.01	0.00	0.00	0.00 CO-107	0.01	0.00
J08093	0107 010705	11	1	G9025		0.01	0.00	0.00	0.00 CO-107	0.01	0.00
J08093	0107 010705	11	1	G9030		0.01	0.00	0.00	0.00 CO-107	0.01	0.00
J08093	0107 010705	11	10	J1100		50.00	1.40	0.00	0.28 CO-42	48.60	1.12
J08093	0107 010705	11	60	Q0136		1800.00	610.80	0.00	122.16 CO-42	1189.20	488.64
J08093	0107 010705	11	10	J1626		400.00	70.90	0.00	14.18 CO-42	329.10	56.72
J08093	0107 010705	11	5	J9293		3850.00	1609.00	0.00	321.80 CO-42	2241.00	1287.20
PT RESP	462.52			CLAIM TOTALS		6378.03	2312.62	0.00	462.52	4065.41	1850.10
											1850.10 NET

[redacted]						[redacted]					
J09682	0114 011405	11	1	99214		190.00	87.18	87.18	0.00 CO-42	82.82	16.10
J09682	0114 011405	11	1	90658		16.00	10.10	0.00	0.00 CO-42	5.90	22.07
J09682	0114 011405	11	1	60008		24.00	22.07	0.00	0.00 CO-42	1.93	32.17
PT RESP	87.18			CLAIM TOTALS		190.00	119.35	87.18	0.00	70.65	32.17
											32.17 NET

[redacted]						[redacted]					
J08093	0114 [redacted]					100.00	56.74	54.26	0.30	44.26	1.18
PT RESP	54.56			CLAIM TOTALS		100.00	56.74	54.26	0.30	44.26	1.18
											1.18 NET

[redacted]

57

REDACTED | Employee
04-3499715 | 288260

04/25/2005
Date Issued

Amount Paid: $570.57

REDACTED
AGAUAM, MA 01001

File Copy This is not a Check

SHEET METAL WORKERS' NATIONAL HEALTH FUND
P.O. Box 1449
Goodlettsville, TN 37070-1449
Phone (615) 859-0131 Toll-free (800) 831-4914

Claim No. 2876148

Check No. 1399684

Explanation of Benefits

SMW+ Program

Dates of Service From	To	Amount Charged	Not Covered	Charges Allowed	Covered Maj Med	Maj Med Paid
12/16/2004	12/16/2004	$6,645.00	$0.00	$570.57	$570.57	$570.57
	Total:	$6,645.00	$0.00	$570.57	$570.57	$570.57

Comments:

Pro REDACTED LYNN PC 01
RES Claim Number: 2876148

MURRAY AND GLYNN PC
PO BOX 3160
ANDOVER, MA 01810

Processed by *Southern Benefit Administrators, Inc.*

REDACTED Employee

04-3499715 296260

57

04/25/2005
Date Issued

Amount Paid: $570.57

REDACTED
Andover, MA 01801

File Copy This is not a Check

SHEET METAL WORKERS' NATIONAL HEALTH FUND
P.O. Box 1449
Goodlettsville, TN 37070-1449
Phone (615) 859-0131 Toll-free (800) 831-4914

Claim No. **2876143** Check No. **1399679**

Explanation of Benefits **SMW+ Program**

Dates of Service From	To	Amount Charged	Non-Covered	Charges Allowed	Covered by Medicare	Medicare Paid
12/16/2004	12/16/2004	$6,645.00	$0.00	$570.57	$570.57	$570.57
Total		$6,645.00	$0.00	$570.57	$570.57	$570.57

Comments:

Provider: MURRAY AND GLYNN PC
Participant SS REDACTED
RES Claim Number: 2876143

01

MURRAY AND GLYNN PC
PO BOX 3160
ANDOVER, MA 01810

Processed by *Southern Benefit Administrators, Inc.*

PLEASE DO NOT STAPLE IN THIS AREA

SHEET METAL WORKERS
PO BOX 1449

GOODLETTSVILLE TN 37070

BOB ATTACHED

CARRIER

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID) X

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY: 03 21 1937 | SEX M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): REDACTED

CITY: AGAWAM | STATE: MA

ZIP CODE: 01001 | TELEPHONE (Include Area Code)

6. PATIENT RELATIONSHIP TO INSURED: Self X | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street): REDACTED

CITY: AGAWAM | STATE: MA

ZIP CODE: 01001 | TELEPHONE (INCLUDING AREA CODE)

8. PATIENT STATUS: Single | Married X | Other

Employed | Full-Time Student | Part-Time Student X

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: REDACTED

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES | NO X

a. INSURED'S DATE OF BIRTH MM DD YY: 03 21 1937 | SEX M X F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: 03 21 1937 | SEX M X F

b. AUTO ACCIDENT? YES | NO X | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO X

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICARE OF MA

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X | NO | If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: DAVID CHADBOURNE MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: B99559

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO X | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. L185.
2. 285.9
3.
4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 01272005	01272005	11	1	J9293		1,2	644.00	1				043499715
2 01272005	01272005	11	1	J7040		1,2	45.00	3				043499715
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER: 043499715 | SSN | EIN X

26. PATIENT'S ACCOUNT NO.: 302320

27. ACCEPT ASSIGNMENT? (For govt. claims see back) YES X | NO

28. TOTAL CHARGE: $ 689.00

29. AMOUNT PAID: $ 624.61

30. BALANCE DUE: $ 64.39

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

PHILIP T GLYNN MD
SIGNED 02/24/2005 DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

GLYNN AND MURRAY OFFICE
299 CAREW STREET, STE 400
SPRINGFIELD MA 01104

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

978 289-1189
GLYNN & MURRAY, PC
PO BOX 3160
ANDOVER MA 01810

PIN # | GRP # 043499715

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER PATIENT AND INSURED INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

2122 DCP

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215 FORM OWCP-1500, APPROVED OMB-0720-001 (CHAMPUS)

NATIONAL HERITAGE INSURANCE COMPANY
PROVIDER #: M20895
CHECK/EFT #:128268310 02/14/05

128268310 100001480
MURRAY AND GLYNN PC
PAGE #: 3 OF 7

MEDICARE REMITTANCE NOTICE

PERF PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
[redacted]											
PT RESP	17.44			CLAIM TOTALS		174.00	87.18	0.00	17.44	86.82	69.74
						174.00	87.18	0.00	17.44		69.74 NET
[redacted]											
PT RESP	35.69			CLAIM TOTALS		174.00	87.18	22.82	12.87	86.82	51.49
						174.00	87.18	22.82	12.87		51.49 NET
[redacted]											
PT RESP	12.19			CLAIM TOTALS		174.00	60.96	0.00	12.19	113.04	48.77
											48.77 NET
[redacted]											
PT RESP	7.34			CLAIM TOTALS		111.00	36.71	0.00	7.34	74.29	29.37
											29.37 NET
[redacted]											
PT RESP	17.44			CLAIM TOTALS		174.00	87.18	0.00	17.44	86.82	69.74
											69.74 NET
[redacted]											
PT RESP	11.15			CLAIM TOTALS		111.00	55.74	0.00	11.15	55.26	44.59
CLAIM INFORMATION FORWARDED TO: METLIFE INS. CO						111.00	55.74	0.00	11.15		44.59 NET
[redacted]											
J09682	0127 012705 11		1	93000		58.00	29.01	22.82	1.24 CO-42	28.99	4.95
PT RESP	111.24			CLAIM TOTALS		232.00	116.19	110.00	1.24	115.81	4.95
											4.95 NET
[redacted]											
PT RESP	17.44			CLAIM TOTALS		174.00	87.18	0.00	17.44 CO-42	86.82	69.74
						174.00	87.18	0.00	17.44		69.74 NET
[redacted]											
J08093	0125 012504 21		1	99253		204.00	100.60	0.00	20.12 CO-42	103.40	80.48
PT RESP	20.12			CLAIM TOTALS		204.00	100.60	0.00	20.12	103.40	80.48
ADJS: PREV PD	0.00	INT		0.00	LATE FILING CHARGE		8.05				72.43 NET
[redacted]											
PT RESP	60.84			CLAIM TOTALS		174.00	87.18	54.26	6.58	86.82	26.34
											26.34 NET
[redacted]											
PT RESP	8.20			CLAIM TOTALS		82.00	40.98	0.00	8.20	41.02	32.78
											32.78 NET
[redacted]											
PT RESP	11.15			CLAIM TOTALS		111.00	55.74	0.00	11.15	55.26	44.59
											44.59 NET

REDACTED

ACNT 302320 ICN 020B033035990 ASG Y MOA MA01

[redacted]				87.00	47.63	0.00	9.51 CO-42	39.47	38.02
[redacted]		1	60359	355.00	196.12	0.00	39.22 CO-42	158.88	156.90
J08093	0127 012705 11	1	69022	0.01	0.01	0.00	0.00		0.01
J08093	0127 012705 11	1	69025	0.01	0.01	0.00	0.00		0.01
J08093	0127 012705 11	1	80031	0.01	0.01	0.00	0.00		0.01
J08093	0127 012705 11	10	J1100	10.00	1.40	0.00	0.28 CO-42	8.60	1.12
J08093	0127 012705 11	1	J9293	644.00	321.80	0.00	64.36 CO-42	322.20	257.44
J08093	0127 012705 11	3	J7040	45.00	0.15	0.00	0.03 CO-42	44.85	0.12
PT RESP	113.40		CLAIM TOTALS	3141.03	567.03	0.00	113.40	574.00	453.63
									453.63 NET

PLEASE DO NOT STAPLE IN THIS AREA

SHEET METAL WORKERS
PO BOX 1449

GOODLETTSVILLE TN 37070

EOB ATTACHED

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE	MEDICAID	CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
	(Medicaid #)	(Sponsor's SSN)	(VA File #)	(SSN or ID)	(SSN) X	(ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY: 03 21 1937 SEX M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial) REDACTED

5. PATIENT'S ADDRESS (No., Street) REDACTED

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other

7. INSURED'S ADDRESS (No., Street): 37 SPRING STREET

CITY: AGAWAM STATE: MA

8. PATIENT STATUS: Single Married X Other

CITY: AGAWAM STATE: MA

ZIP CODE: 01001 TELEPHONE (Include Area Code)

Employed Full-Time Student Part-Time Student

ZIP CODE: 01001 TELEPHONE (INCLUDING AREA CODE)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER REDACTED

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO X

a. INSURED'S DATE OF BIRTH MM DD YY: 03 21 1937 SEX M X F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: 03 21 1937 SEX M X F

b. AUTO ACCIDENT? YES NO X PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO X

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICARE OF MA

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? X YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: DAVID CHADBOURNE MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: B99559

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES X NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 285.9
2. 185
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 01 28 2005	01 28 2005	11	1	G0351		1,2	38.00	1				043499715
2 01 28 2005	01 28 2005	11	1	Q0136		1,2	1800.00	60				043499715
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER: 043499715 SSN EIN X

26. PATIENT'S ACCOUNT NO.: 302680

27. ACCEPT ASSIGNMENT? (For govt. claims see back) X YES NO

28. TOTAL CHARGE: $ 1838.00

29. AMOUNT PAID: $ 1711.74

30. BALANCE DUE: $ 126.26

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

PHILIP T GLYNN MD

SIGNED 02/24/2005 DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

GLYNN AND MURRAY OFFICE
299 CAREW STREET, STE 400
SPRINGFIELD MA 01104

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # 978 289-1189

GLYNN & MURRAY, PC
PO BOX 3160
ANDOVER MA 01810

PIN # GRP # 043499715

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

3122 DEP

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215 FORM OWCP-1500, APPROVED OMB-0720-001 (CHAMPUS)

CARRIER

CARRIER PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NATIONAL HERITAGE INSURANCE COMPANY
PROVIDER #: N20895
CHECK/EFT #:128268310 02/14/05

128268310 100001480
MURRAY AND GLYNN PC
PAGE #: 4 OF 7

MEDICARE
REMITTANCE
NOTICE

REDACTED

PERF PROV	SERV DATE POS	NOS PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
				ACNT 302680			ICN 0205033036000	ASG Y MOA MA01	
J08093	0128 012805 11	1 80351		38.00	20.52	0.00	4.10 CO-42	17.48	16.42
J08093	0128 012805 11	60 00136		1800.00	610.80	0.00	122.16 CO-42	1189.20	488.64
PT RESP	126.76	CLAIM TOTALS		1838.00	631.32	0.00	126.26	1206.68	505.06
									505.06 NET
[redacted]									
J08093	0126 012605 11	1 93000		58.00	29.01	22.82	1.24 CO-42	28.99	4.54
J08093	0126 012605 11	1 80107		15.00	4.54	0.00	0.00 CO-42	10.46	9.49
PT RESP	111.24	CLAIM TOTALS		247.00	120.73	110.00	1.24	126.27	9.49 NET
CLAIM INFORMATION FORWARDED TO: BC/BS OF NJ									
[redacted]									
PT RESP	12.19	CLAIM TOTALS		174.00	60.96	0.00	12.19	113.04	48.77 NET
[redacted]									
PT RESP	17.44	CLAIM TOTALS		174.00	87.18	0.00	17.44	86.82	69.74
									69.74 NET
[redacted]									
J09682	0126 012605 11	1 93000		58.00	29.01	0.00	5.80 CO-42	28.99	64.06
PT RESP	52.13	CLAIM TOTALS		232.00	116.19	36.12	16.01	115.81	64.06 NET
[redacted]									
J08093	0125 012505 11	1 80107		15.00	0.00	0.00	0.00 CO-119	15.00	
REM: N25---									54.14
PT RESP	33.04	CLAIM TOTALS		189.00	87.18	19.61	13.63	101.82	54.14 NET
[redacted]									
J09682	0126 012605 11	1 93000		58.00	29.01	0.00	5.80 CO-42	28.99	23.21
J09682	0126 012605 11	1 90658		20.00	10.10	0.00	0.00 CO 42	9.90	10.10
J09682	0126 012605 11	1 60008		40.00	22.07	0.00	0.00 CO-42	17.93	22.07
J09682	0126 012605 11	1 94760		10.00	0.00	0.00	0.00 CO-815	10.00	0.00
PT RESP	23.24	CLAIM TOTALS		302.00	148.36	0.00	23.24	153.64	125.12
									125.12 NET
[redacted]									
PT RESP	17.44	CLAIM TOTALS		174.00	87.18	0.00	17.44	86.82	69.74
									69.74 NET
[redacted]									
J09682	0119 011905 11	1 90658		20.00	10.10	0.00	0.00 CO-42	9.90	10.10
J09682	0119 011905 11	1 60008		40.00	22.07	0.00	0.00 CO-42	17.93	22.07
PT RESP	60.84	CLAIM TOTALS		234.00	139.35	54.26	6.58	114.65	58.51
									58.51 NET
[redacted]									
J08093	0127 012705 11	1 80349		87.00	47.53	0.00	9.51 CO-42	39.47	38.02
J08093	0127 012705 11	2 60358		292.00	159.88	0.00	31.98 CO-42	132.12	127.90
J08093	0127 012705 11	1 60359		355.00	196.12	0.00	39.22 CO-42	158.88	156.90
J08093	0127 012705 11	1 60360		80.00	43.27	0.00	8.65 CO-42	36.73	34.62
J08093	0127 012705 11	1 89022		0.01	0.01	0.00	0.00		0.01
J08093	0127 012705 11	1 89025		0.01	0.01	0.00	0.00		0.01
J08093	0127 012705 11	1 69030		0.01	0.01	0.00	0.00		0.01
J08093	0127 012705 11	50 J9035		5700.00	2854.00	0.00	570.80 CO-42	2846.00	2283.20
J08093	0127 012705 11	10 J1100		10.00	1.40	0.00	0.28 CO-42	8.60	1.12
J08093	0127 012705 11	2 J9190		6.00	3.36	0.00	0.67 CO-42	2.64	2.69
J08093	0127 012705 11	9 J9206		2880.00	1130.22	0.00	226.04 CO-42	1749.78	904.18
J08093	0127 012705 11	1 J0640		15.00	1.30	0.00	0.26 CO-42	13.70	1.04
J08093	0127 012705 11	4 J7040		60.00	0.20	0.00	0.04 CO-42	59.80	0.16
PT RESP	887.45	CLAIM TOTALS		9485.03	4437.31	0.00	887.45	5047.72	3549.86
									3549.86 NET
CLAIM INFORMATION FORWARDED TO: UNICARE									

PLEASE DO NOT STAPLE IN THIS AREA

SHEET METAL WORKERS
PO BOX 1449
GOODLETTSVILLE TN 37070

EOB ATTACHED

CARRIER

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [X] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY: 03 21 1937 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial) REDACTED

5. PATIENT'S ADDRESS (No., Street) REDACTED

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street) REDACTED

CITY: AGAWAM STATE: MA

8. PATIENT STATUS: Single [ ] Married [X] Other [ ]

CITY: AGAWAM STATE: MA

ZIP CODE: 01001 TELEPHONE (Include Area Code):

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: 01001 TELEPHONE (INCLUDING AREA CODE):

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER REDACTED

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 03 21 1937 SEX M [X] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: 03 21 1937 SEX M [X] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICARE OF MA

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO [ ] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: DAVID CHADBOURNE MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: B99559

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 185.
2. 285.9
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 01272005	01272005	11	1	G0349		1,2	87.00	1				043499715
2 01272005	01272005	11	1	G0359		1,2	355.00	1				043499715
3 01272005	01272005	11	1	G9022		1,2	0.01	1				043499715
4 01272005	01272005	11	1	G9025		1,2	0.01	1				043499715
5 01272005	01272005	11	1	G9031		1,2	0.01	1				043499715
6 01272005	01272005	11	1	J1100		1,2	10.00	10				043499715

25. FEDERAL TAX I.D. NUMBER: 043499715 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 302320

27. ACCEPT ASSIGNMENT? (For govt. claims see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 452.03

29. AMOUNT PAID: $ 403.02

30. BALANCE DUE: $ 49.01

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

PHILIP T GLYNN MD
SIGNED 02/24/2005 DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

GLYNN AND MURRAY OFFICE
299 CAREW STREET, STE 400
SPRINGFIELD MA 01104

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # 978 289-1189

GLYNN & MURRAY, PC
PO BOX 3160
ANDOVER MA 01810

PIN # GRP # 043499715

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER PATIENT AND INSURED INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215 FORM OWCP-1500, APPROVED OMB-0720-001 (CHAMPUS)

2/22 DFP

NATIONAL HERITAGE INSURANCE COMPANY
PROVIDER #: M20895
CHECK/EFT #:128268310 02/14/05

128268310 100001480
MURRAY AND GLYNN PC
PAGE #: 3 OF 7

MEDICARE REMITTANCE NOTICE

PERF PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
[redacted]											
PT RESP	17.44			CLAIM TOTALS		174.00	87.18	0.00	17.44	86.82	69.74
											69.74 NET
[redacted]											
PT RESP	35.69			CLAIM TOTALS		174.00	87.18	22.82	12.87 CO-42	86.82	51.49
											51.49 NET
[redacted]											
J08093	0126 012605 22	1	99214			174.00	60.96	0.00	12.19 CO-86	113.04	48.77
PT RESP	12.19			CLAIM TOTALS		174.00	60.96	0.00	12.19	113.04	48.77 NET
[redacted]											
J08093	[redacted]	1	99213			111.00	36.71	0.00	7.34 CO-86	74.29	29.37
PT RESP	7.34			CLAIM TOTALS		111.00	36.71	0.00	7.34	74.29	29.37 NET
[redacted]											
[redacted]	0125 012505 11	1	99214			174.00	87.18	0.00	17.44 CO-42	86.82	69.74
PT RESP	17.44			CLAIM TOTALS		174.00	87.18	0.00	17.44	86.82	69.74 NET
[redacted]											
J09682	0125 012505 11	1	99213			111.00	55.74	0.00	11.15 CO-42	55.26	44.59
PT RESP	11.15			CLAIM TOTALS		111.00	55.74	0.00	11.15	55.26	44.59 NET
CLAIM INFORMATION FORWARDED TO: METLIFE INS. CO											
[redacted]											
J09682	0127 012705 11	1	93000			58.00	29.01	22.82	1.24 CO-42	28.99	4.95
PT RESP	111.24			CLAIM TOTALS		232.00	116.19	110.00	1.24	115.81	4.95
											4.95 NET
[redacted]											
PT RESP	17.44			CLAIM TOTALS		174.00	87.18	0.00	17.44	86.82	69.74
											69.74 NET
[redacted]											
J08093	0125 012504 21	1	99253			204.00	100.60	0.00	20.12 CO-42	103.40	80.48
PT RESP	20.12			CLAIM TOTALS		204.00	100.60	0.00	20.12	103.40	80.48
ADJS; PREV PD 0.00 INT 0.00 LATE FILING CHARGE 8.05											72.43 NET
[redacted]											
[redacted]	0127 012705 11	1	[redacted]			174.00	87.18	54.26	6.58	86.82	26.34
PT RESP	60.84			CLAIM TOTALS							26.34 NET
[redacted]											
PT RESP	[redacted]			CLAIM TOTALS		82.00	40.98	0.00	8.20	41.02	32.78
											32.78 NET
[redacted]											
J08093	0127 012705 11	1	[redacted]			111.00	55.74	0.00	11.15 CO-42	55.26	44.59
PT RESP	11.15			CLAIM TOTALS		111.00	55.74	0.00	11.15	55.26	44.59 NET

[redacted]

					ACNT 302320			ICN 02D6033035990	AS6 Y MOA MA01	
J08093	[redacted]	11	[redacted]		87.00	47.63	0.00	9.61 CO-42	39.47	38.02
J08093	[redacted]	11	[redacted]		355.00	196.12	0.00	39.22 CO-42	158.88	156.90
J08093	[redacted]		[redacted]		0.01	0.01	0.00	0.00		0.01
J08093	0127	012705	11	1 69025	0.01	0.01	0.00	0.00		0.01
J08093	0127	012705	11	1 69031	0.01	0.01	0.00	0.00		0.01
J08093	0127	012705	11	10 J1100	10.00	1.40	0.00	0.28 CO-42	8.60	1.12
J08093	0127	012705	11	1 J9293	644.00	321.80	0.00	64.36 CO-42	322.20	257.44
J08093	0127	012705	11	3 J7040	45.00	0.15	0.00	0.03 CO-42	44.85	0.12
PT RESP	113.40			CLAIM TOTALS	1141.03	567.03	0.00	113.40	574.00	453.63
										453.63 NET

PLEASE DO NOT STAPLE IN THIS AREA

SHEET METAL WORKERS
PO BOX 1449

GOODLETTSVILLE TN 37070

EOB ATTACHED

CARRIER

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE	MEDICAID	CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
	(Medicaid #)	(Sponsor's SSN)	(VA File #)	(SSN or ID)	(SSN)	X (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
REDACTED	03 21 1937 M X F	REDACTED
5. PATIENT'S ADDRESS (No. Street)	6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other	7. INSURED'S ADDRESS (No. Street)
CITY: AGAWAM	STATE: MA	8. PATIENT STATUS: Single Married X Other; Employed Full-Time Student Part-Time Student	CITY: AGAWAM	STATE: MA
ZIP CODE: 01001	TELEPHONE (Include Area Code)	ZIP CODE: 01001	TELEPHONE (INCLUDING AREA CODE) (
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): REDACTED	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES X NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX: 03 21 1937 M X F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX: 03 21 1937 M X F	b. AUTO ACCIDENT? YES X NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES X NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICARE OF MA	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? X YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: DAVID CHADBOURNE MD	17a. I.D. NUMBER OF REFERRING PHYSICIAN: B99559	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES X NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE): 1. 285.9 2. 185 3. 4.		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.; 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. Place of Service	C. Type of Service	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS CODE	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. EMG	J. COB	K. RESERVED FOR LOCAL USE
1 01 13 2005	01 13 2005	11	1	G0351		1,2	38.00	1				043499715
2 01 13 2005	01 13 2005	11	1	Q0136		1,2	1200.00	60				043499715
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
043499715		X	295630	X YES NO	$ 1238.00	$ 1111.74	$ 126.26

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
PHILIP T GLYNN MD SIGNED 02/24/2005 DATE	GLYNN AND MURRAY OFFICE 299 CAREW STREET, STE 400 SPRINGFIELD MA 01104	GLYNN & MURRAY, PC PO BOX 3160 ANDOVER MA 01810 978 289-1189 PIN # GRP # 043499715

CARRIER PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

211 Le Dep

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215 FORM CWCP-1500, APPROVED OMB-0720-001 (CHAMPUS)

NATIONAL HERITAGE INSURANCE COMPANY
PROVIDER #: H20895
CHECK/EFT #: 128253261 02/07/05

128253261 100001298
MURRAY AND GLYNN PC
PAGE #: 4 OF 8

MEDICARE
REMITTANCE
NOTICE

PERF PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT		PROV PD
[redacted]												
J09682	0120 012005	11	1	[redacted]		20.00	10.10	0.00	0.00	CO-42	9.90	10.10
J09682	0120 012005	11	1	60008		40.00	22.07	0.00	0.00	CO-42	17.93	22.07
PT RESP	55.74			CLAIM TOTALS		171.00	87.91	55.74	0.00		83.09	32.17
												32.17 NET
[redacted]											NA18	
J08093	0120 012005	11	1	99215		252.00	126.01	86.69	7.86	CO-42	125.99	31.46
PT RESP	94.55			CLAIM TOTALS		252.00	126.01	86.69	7.86		125.99	31.46
												31.46 NET
[redacted]						[redacted]	87.18	0.00	17.44	CO-42	62.82	69.74
PT RESP	17.44			CLAIM TOTALS		150.00	87.18	0.00	17.44		62.82	69.74
												69.74 NET
[redacted]												
PT RESP	35.85			CLAIM TOTALS		361.00	179.23	0.00	35.85		181.77	143.38
												143.38 NET
CLAIM INFORMATION FORWARDED TO: CIGNA												
[redacted]												
PT RESP	79.86			CLAIM TOTALS		174.00	87.18	78.03	1.83		86.82	7.32
												7.32 NET
CLAIM INFORMATION FORWARDED TO: CIGNA												
REDACTED						ACNT 295630			ICN 0205024095480		ASG Y MOA MA01	
						38.00	20.52	0.00	4.10	CO-42	17.48	16.42
						1200.00	610.80	0.00	122.16	CO-42	589.20	488.64
PT RESP	126.26			CLAIM TOTALS		1238.00	631.32	0.00	126.26		606.68	505.06
												505.06 NET
[redacted]												
J08093	0118 011805	11	1	60348		53.00	28.42	2.44	5.20	CO-42	24.58	20.78
J08093	0118 011805	11	3	J2430		354.00	177.18	0.00	35.44	CO-42	176.82	141.74
J08093	0118 011805	11	1	J7040		1.00	0.05	0.00	0.01	CO-42	0.95	0.04
J08093	0118 011805	11	1	69021		0.01	0.00	0.00	0.00	CO 107	0.01	0.00
J08093	0118 011805	11	1	69026		0.01	0.00	0.00	0.00	CO-107	0.01	0.00
J08093	0118 011805	11	1	69031		0.01	0.00	0.00	0.00	CO-107	0.01	0.00
PT RESP	129.85			CLAIM TOTALS		568.03	292.41	89.20	40.65		273.62	162.56
												162.56 NET
[redacted]						293.00	146.45	0.00	[redacted]			
PT RESP	29.29			CLAIM TOTALS		293.00	146.45	0.00	29.29		146.55	117.16
												117.16 NET
[redacted]						163.00	[redacted]					
PT RESP	16.32			CLAIM TOTALS		163.00	81.60	0.00	16.32		81.40	65.28
												65.28 NET
[redacted]												
J09682	0120 012005	11	1	93000		58.00	29.01	0.00	5.80	CO-42	28.99	23.21
J09682	0120 012005	11	1	80107		15.00	4.54	0.00	0.00	CO-42	10.46	4.54
PT RESP	122.53			CLAIM TOTALS		360.00	177.21	110.00	12.53		182.79	54.68
												54.68 NET
CLAIM INFORMATION FORWARDED TO: UNICARE												
[redacted]						293.00	[redacted]					
PT RESP	29.29			CLAIM TOTALS		293.00	146.45	0.00	29.29		146.55	117.16
												117.16 NET
[redacted]				99213		111.00	36.71	6.88	5.97	CO-B6	74.29	[redacted]
PT RESP	12.85			CLAIM TOTALS		111.00	36.71	6.88	5.97		74.29	23.86
												23.86 NET
[redacted]						[redacted]				CO-42	10.46	4.54
PT RESP	0.00			CLAIM TOTALS		16.00	4.54	0.00	0.00		10.46	4.54
												4.54 NET

[redacted] Employee

04-34947D 292970

57

04/25/2005
Date Issued

Amount Paid: $462.52

[redacted]
ACTON, MA 01001

File Copy This is not a Check

SHEET METAL WORKERS' NATIONAL HEALTH FUND
P.O. Box 1449
Goodlettsville, TN 37070-1449
Phone (615) 859-0131 Toll-free (800) 831-4914

Claim No. **2876147**

Check No. **1399683**

Explanation of Benefits **SMW+ Program**

Dates of Service From	To	Amount Charged	Non-Covered Charges	Covered Charges	Plan Med Allowed	Plan Med Paid
01/07/2005	01/07/2005	$6,378.03	$0.00	$462.52	$462.52	$462.52
[redacted]						

Comments:

[redacted]

Provider: [redacted] MURRAY AND GLYNN PC 01
Participant SSN:
RES Claim Number: 2876147

[redacted]
MURRAY AND GLYNN PC
PO BOX 3160
ANDOVER, MA 01810

Processed by *Southern Benefit Administrators, Inc.*

REDACTED		Employee
04-3499715	302320	

57

04/25/2005
Date Issued

Amount Paid: $126.26

REDACTED
AGAUAM, MA 01001

File Copy This is not a Check

SHEET METAL WORKERS' NATIONAL HEALTH FUND
P.O. Box 1449
Goodlettsville, TN 37070-1449
Phone (615) 859-0131 Toll-free (800) 831-4914

Claim No. **2876145** Check No. **1399681**

Explanation of Benefits **SMW+ Program**

Dates of Service From	To	Amount Charged	Non-Covered Charges	Covered Allowed	Ma Med	Ma Med Paid
01/28/2005	01/28/2005	$1,838.00	$0.00	$126.26	$126.26	$126.26
	Total	$1,838.00	$0.00	$126.26	$126.26	$126.26

Comments:

Payee/Recipient:
MURRAY AND GLYNN PC
PO BOX 3160
ANDOVER, MA 01810

Provider: MURRAY AND GLYNN PC
Participant SS REDACTED
RES Claim Number: 2876145

01

Processed by *Southern Benefit Administrators, Inc.*

PLEASE DO NOT STAPLE IN THIS AREA

SHEET METAL WORKERS
PO BOX 1449

GOODLETTSVILLE TN 37070

EOB ATTACHED

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE	MEDICAID	CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
	(Medicaid #)	(Sponsor's SSN)	(VA File #)	(SSN or ID)	(SSN)	X (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): REDACTED

3. PATIENT'S BIRTH DATE: 03 21 1937 SEX: M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): REDACTED

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY: AGAWAM STATE: MA

8. PATIENT STATUS: Single Married X Other; Employed Full-Time Student Part-Time Student

CITY: AGAWAM STATE: MA

ZIP CODE: 01001 TELEPHONE (Include Area Code)

ZIP CODE: 01001 TELEPHONE (INCLUDING AREA CODE)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): REDACTED

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO X

a. INSURED'S DATE OF BIRTH: 03 21 1937 SEX: M X F

b. OTHER INSURED'S DATE OF BIRTH: 03 21 1937 SEX: M X F

b. AUTO ACCIDENT? YES NO X PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO X

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICARE OF MA

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? X YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: DAVID CHADBOURNE MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: B99559

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES X NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. L185
2. 285.9
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 01272005	01272005	11	1	G0349		1,2	87.00	1				043499715
2 01272005	01272005	11	1	G0359		1,2	355.00	1				043499715
3 01272005	01272005	11	1	G9022		1,2	0.01	1				043499715
4 01272005	01272005	11	1	G9025		1,2	0.01	1				043499715
5 01272005	01272005	11	1	G9031		1,2	0.01	1				043499715
6 01272005	01272005	11	1	J1100		1,2	10.00	10				043499715

25. FEDERAL TAX I.D. NUMBER: 043499715 SSN EIN X

26. PATIENT'S ACCOUNT NO.: 302320

27. ACCEPT ASSIGNMENT? (For govt. claims see back) X YES NO

28. TOTAL CHARGE: $ 452.03

29. AMOUNT PAID: $ 377.01

30. BALANCE DUE: $ 75.02

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

PHILIP T GLYNN MD

SIGNED 03/21/2005 DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

GLYNN AND MURRAY OFFICE
299 CAREW STREET, STE 400
SPRINGFIELD MA 01104

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # 978 289-1189

GLYNN & MURRAY, PC
PO BOX 3160
ANDOVER MA 01810

PIN # GRP # 043499715

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

R/U DAO

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215 FORM OWCP-1500, APPROVED OMB-0720-001 (CHAMPUS)

CARRIER

CARRIER PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NATIONAL HERITAGE INSURANCE COMPANY
75 WILLIAM TERRY DRIVE
HINGHAM MA 02044
877-567-3130

128307012 000000557

MEDICARE REMITTANCE NOTICE

MURRAY AND GLYNN PC
PO BOX 3180
ANDOVER, MA 01810-0803

PROVIDER #: MZ0895
PAGE #: 1 OF 4
DATE: 03/01/05
CHECK/EFT #: 128307012

The Centers for Medicare & Medicaid Services has selected a random sample of providers to participate in a satisfaction survey. Survey responses are due by March 31, 2005. If you received a survey packet, please complete and submit your survey responses as soon as possible. Your feedback is very important to us.

PERF PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
[redacted]			1	99214		174.00	87.18	15.11	14.41 CO-42	86.82	57.65
PT RESP 29.52				CLAIM TOTALS		174.00	87.18	15.11	14.41	86.82	57.65
											57.65 NET

REDACTED

ACNT 302320 ICN 8305059900144 ASG Y MOA MA03 MA62 MA67

J08093	0127	012705	11	1	G0349	87.00	47.53	0.00	9.51 CO-42	39.47	38.02
J08093	0127	012705	11	1	G0359	355.00	196.12	0.00	39.22 CO-42	158.88	156.90
J08093	0127	012705	11	1	G9022	43.34	43.34	0.00	8.67		34.67
J08093	0127	012705	11	1	G9025	43.33	43.33	0.00	8.67		34.66
J08093	0127	012705	11	1	G9031	43.33	43.33	0.00	8.67		34.66
J08093	0127	012705	11	10	J1100	10.00	1.40	0.00	0.28 CO-42	8.60	1.12
J08093	0127	012705	11	1	J9293	644.00	321.80	0.00	64.36 CO-42	322.20	257.44
J08093	0127	012705	11	3	J7040	45.00	0.15	0.00	0.03 CO-42	44.85	0.12
PT RESP 139.41					CLAIM TOTALS	1271.00	697.00	0.00	139.41	574.00	557.59
ADJS: PREV PD 453.63 INT 0.00 LATE FILING CHARGE 0.00											103.96 NET

PD
M3
E0
09
8D
54

[redacted]

PLEASE DO NOT STAPLE IN THIS AREA

SHEET METAL WORKERS
PO BOX 1449

GOODLETTSVILLE TN 37070

EOB ATTACHED

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER [X] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): REDACTED

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE: 03 21 1937 | SEX: M [X] F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): REDACTED

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse Child Other

CITY: AGAWAM | STATE: MA

8. PATIENT STATUS: Single Married [X] Other

Employed Full-Time Student Part-Time Student

CITY: AGAWAM | STATE: MA

ZIP CODE: 01001 | TELEPHONE (Include Area Code): (

ZIP CODE: 01001 | TELEPHONE (INCLUDING AREA CODE)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: REDACTED

a. EMPLOYMENT? (CURRENT OR PREVIOUS): YES NO [X]

a. INSURED'S DATE OF BIRTH: 03 21 1937 | SEX: M [X] F

b. OTHER INSURED'S DATE OF BIRTH: 03 21 1937 | SEX: M [X] F

b. AUTO ACCIDENT? YES NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICARE OF MA

10d. RESERVED FOR LOCAL USE

9. IS THERE ANOTHER HEALTH BENEFIT PLAN? [X] YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: DAVID CHADBOURNE MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: B99559

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [X] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 185
2. 285.9
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 01272005	01272005	11	1	J9293		1,2	644.00	1				043499715
2 01272005	01272005	11	1	J7040		1,2	45.00	3				043499715
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER: 043499715 SSN EIN [X]

26. PATIENT'S ACCOUNT NO.: 302320

27. ACCEPT ASSIGNMENT? (For govt. claims see back) [X] YES NO

28. TOTAL CHARGE: $ 689.00

29. AMOUNT PAID: $ 624.61

30. BALANCE DUE: $ 64.39

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

PHILIP T GLYNN MD

SIGNED 03/21/2005 DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

GLYNN AND MURRAY OFFICE
299 CAREW STREET, STE 400
SPRINGFIELD MA 01104

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

978 289-1189
GLYNN & MURRAY, PC
PO BOX 3160
ANDOVER MA 01810

PIN # GRP # 043499715

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

3/11 D-cp

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215 FORM OWCP-1500, APPROVED OMB-0720-001 (CHAMPUS)

CARRIER

CARRIER PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NATIONAL HERITAGE INSURANCE COMPANY
75 WILLIAM TERRY DRIVE
HINGHAM MA 02044
877-567-3130

128307012 000000557

MEDICARE REMITTANCE NOTICE

MURRAY AND GLYNN PC
PO BOX 3160
ANDOVER, MA 01810-0803

PROVIDER #: M20895
PAGE #: 1 OF 4
DATE: 03/01/05
CHECK/EFT #: 128307012

****
* The Centers for Medicare & Medicaid Services has selected a random sample of *
* providers to participate in a satisfaction survey. Survey responses are due *
* by March 31, 2005. If you received a survey packet, please complete and *
* submit your survey responses as soon as possible. Your feedback is very *
* important to us. *
****

PERF PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	[redacted]				PRP/RC-AMT	PROV PD
[redacted]												
PT RESP	29.62			CLAIM TOTALS		174.00	87.18	15.11	14.41		86.82	57.66
												57.66 NET
REDACTED						ACNT 302320		ICN 8305059900144	ASG Y	MOA MA62 MA67 MADJ		
J08093	0127 012705	11	1	G0349		87.00	47.53	0.00	9.51	CO-42	39.47	38.02
J08093	0127 012705	11	1	G0359		355.00	196.12	0.00	39.22	CO-42	158.88	156.90
J08093	0127 012705	11	1	69022		43.34	43.34	0.00	8.67			34.67
J08093	0127 012705	11	1	69025		43.33	43.33	0.00	8.67			34.66
J08093	0127 012705	11	1	69031		43.33	43.33	0.00	8.67			34.66
J08093	0127 012705	11	30	J1100		10.00	1.40	0.00	0.28	CO-42	8.60	1.12
J08093	0127 012705	11	1	J9293		644.00	321.80	0.00	64.36	CO-42	322.20	257.44
J08093	0127 012705	11	3	J7040		45.00	0.15	0.00	0.03	CO-42	44.85	0.12
PT RESP	139.41			CLAIM TOTALS		1271.00	697.00	0.00	139.41		574.00	557.59
ADJS: PREV PD	453.63	INT		0.00	LATE FILING CHARGE		0.00					103.96 NET

[redacted]

PLEASE DO NOT STAPLE IN THIS AREA

SHEET METAL WORKERS
PO BOX 1449
GOODLETTSVILLE TN 37070

EOB ATTACHED

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID) [X]

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) — REDACTED

3. PATIENT'S BIRTH DATE MM DD YY: 03 21 1937 | SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial) — REDACTED

5. PATIENT'S ADDRESS (No., Street) — REDACTED

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: AGAWAM | STATE: MA

8. PATIENT STATUS: Single [ ] Married [X] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: AGAWAM | STATE: MA

ZIP CODE: 01001 | TELEPHONE (Include Area Code): (

ZIP CODE: 01001 | TELEPHONE (INCLUDING AREA CODE): (

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER — REDACTED

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 03 21 1937 | SEX M [X] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: 03 21 1937 | SEX M [X] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICARE OF MA

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO [ ] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: DAVID CHADBOURNE MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN: B99559

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 185
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 01072005	01072005	11	1	G0349		1	45.00	1				043499715
2 01072005	01072005	11	1	G0353		1	30.00	1				043499715
3 01072005	01072005	11	1	G0359		1	182.00	1				043499715
4 01072005	01072005	11	1	G9022		1	0.01	1				043499715
5 01072005	01072005	11	1	G9025		1	0.01	1				043499715
6 01072005	01072005	11	1	G9030		1	0.01	1				043499715

25. FEDERAL TAX I.D. NUMBER: 043499715 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 292970

27. ACCEPT ASSIGNMENT? (For govt. claims see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 257.03

29. AMOUNT PAID: $ 179.62

30. BALANCE DUE: $ 77.41

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

PHILIP T GLYNN MD
SIGNED 03/21/2005 DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

GLYNN AND MURRAY OFFICE
299 CAREW STREET, STE 400
SPRINGFIELD MA 01104

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # 978 289-1189

GLYNN & MURRAY, PC
PO BOX 3160
ANDOVER MA 01810

PIN # GRP # 043499715

CARRIER

CARRIER PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) 3/14 DRP PLEASE PRINT OR TYPE

APPROVED OMB-0930-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215 FORM OWCP-1500, APPROVED OMB-0720-001 (CHAMPUS)

NATIONAL HERITAGE INSURANCE COMPANY
75 WILLIAM TERRY DRIVE
HINGHAM MA 02044
877-567-3130

128313118 000000185

MEDICARE REMITTANCE NOTICE

MURRAY AND GLYNN PC
PO BOX 3160
ANDOVER, MA 01810-0803

PROVIDER #: M20895
PAGE #: 1 OF 3
DATE: 03/03/06
CHECK/EFT #: 128313118

The Centers for Medicare & Medicaid Services has selected a random sample of providers to participate in a satisfaction survey. Survey responses are due by March 31, 2005. If you received a survey packet, please complete and submit your survey responses as soon as possible. Your feedback is very important to us.

[redacted]

PERF PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
						ACNT 292970			ICN 8305061107030	AS6 Y MOA MA03	MA62 MA67
J08093	0107 010705	11	1	60240		45.00	45.00	0.00	9.00		36.00
J08093	0107 010705	11	1	60351		21.00	20.52	0.00	4.10 CO-42	0.48	16.42
J08093	0107 010705	11	1	60354		30.00	30.00	0.00	6.00		24.00
J08093	0107 010705	11	1	80359		182.00	182.00	0.00	36.40		145.60
J08093	0107 010705	11	1	69022		43.34	43.34	0.00	8.67		34.67
J08093	0107 010705	11	1	69026		43.33	43.33	0.00	8.67		34.66
J08093	0107 010705	11	1	69030		43.33	43.33	0.00	8.67		34.66
J08093	0107 010705	11	10	J1100		50.00	1.40	0.00	0.28 CO-42	48.60	1.12
J08093	0107 010705	11	60	Q0136		1800.00	610.80	0.00	122.16 CO-42	1189.20	488.64
J08093	0107 010705	11	10	J1626		400.00	70.90	0.00	14.18 CO-42	329.10	56.72
J08093	0107 010705	11	5	J9293		3850.00	1609.00	0.00	321.80 CO-42	2241.00	1287.20
PT RESP 539.93				CLAIM TOTALS		6508.00	2699.62	0.00	539.93	3808.38	2159.69
ADJS: PREV PD 1850.10 INT 0.00 LATE FILING CHARGE 0.00											309.56 NET

[redacted]

J09682	0211 021105	11	1	93010	26QU	14.00	0.00	0.00	0.00 CO-B18	14.00	0.00
REM: M51											
PT RESP 0.00				CLAIM TOTALS		14.00	0.00	0.00	0.00	14.00	0.00
											0.00 NET

[redacted]

57

[illegible]	[illegible]	[illegible]
REDACTED		Employee
[illegible]	[illegible]	
04-3499715	302320	

04/28/2005
Date Issued

Amount Paid: $139.41

REDACTED

AGAUAM, MA 01001

File Copy This is not a Check

SHEET METAL WORKERS' NATIONAL HEALTH FUND
P.O. Box 1449
Goodlettsville, TN 37070-1449
Phone (615) 859-0131 Toll-free (800) 831-4914

Claim No. **2880080**

Check No. **1403261**

Explanation of Benefits

SMW+ Program

Dates of Service From	To	Amount Charged	Not Covered	Charges Allowed	Covered Mar Med	Mar Med Paid
01/27/2005	01/27/2005	$1,271.00	$0.00	$139.41	$139.41	$139.41
Total		$1,271.00	$0.00	$139.41	$139.41	$139.41

Comments:

Provider: GLYNN & MURRAY
Participant S REDACTED
RES Claim Number: 2880080

01

Payment made to:

GLYNN & MURRAY
PO BOX 3160
ANDOVER, MA 01810

Processed by *Southern Benefit Administrators, Inc.*